Department of Health and Social Services

Mission

To promote and protect the health and well being of Alaskans.

Core Services

- Provide the highest quality of life in a safe home environment for older Alaskans and Veterans.
- Manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.
- Promote safe children and strong families.
- Manage health care coverage for Alaskans in need.
- Hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote the independence of Alaskan seniors and persons with physical and developmental disabilities.
- Provide quality administrative services in support of the department's mission.

Priority Programs - Key Performance Indicators

(Additional performance information is available on the web at http://omb.alaska.gov/results.)

FY10 Current Capacity (in thousands)

Funding				Positions		
GF Funds	Federal Funds	Other Funds	Total Funds	Full Time	Part Time	Non Perm
$832,513.0	$1,081,482.7	$160,784.6	$2,074,780.3	3,474	93	123

Vulnerable Populations

Program strategies work to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society.

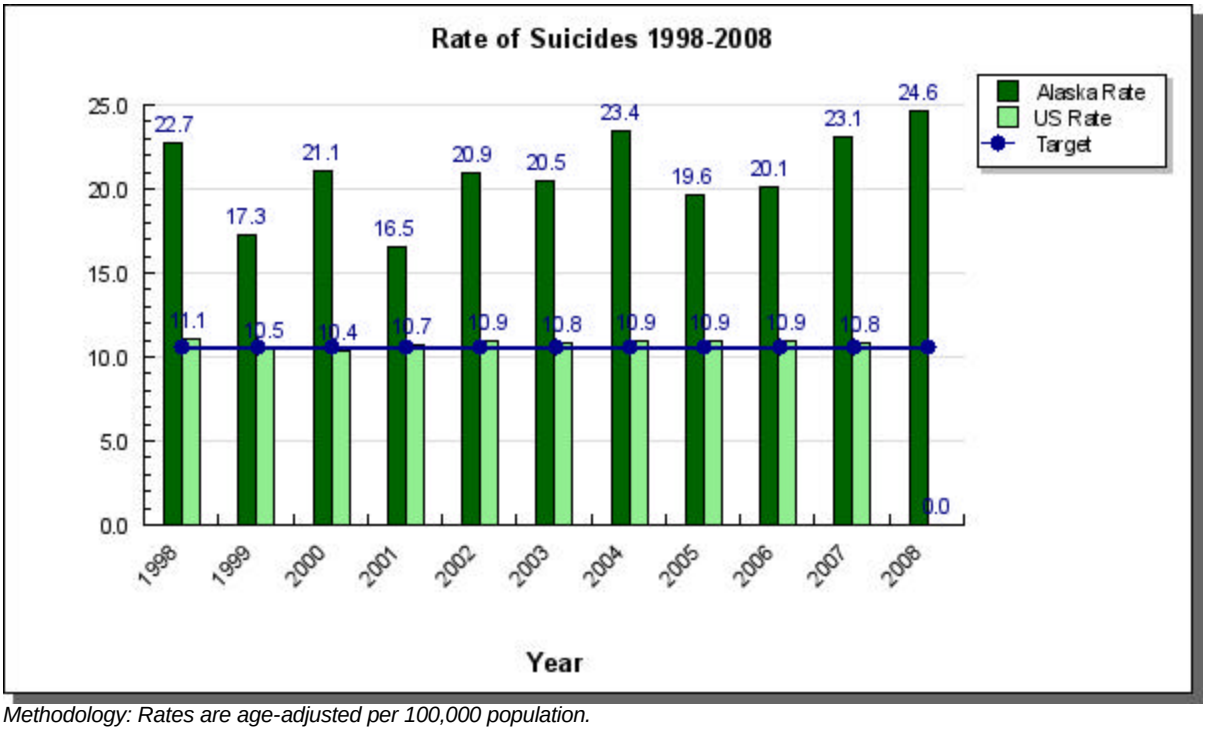
FY10 Current Capacity (in thousands)

Funding				Positions		
GF Funds	Federal Funds	Other Funds	Total Funds	Full Time	Part Time	Non Perm
$402,255.2	$311,597.0	$73,663.2	$787,515.4	1,995	30	58

Key indicator from: Department of Health and Social Services

Target: To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population.

Status: Preliminary data for 2008 indicates an Alaska suicide death rate of 24.6 suicides for all ages per 100,000 population. This rate is more than double the stated target of 10.6.



Methodology: Rates are age-adjusted per 100,000 population.

** The 2008 Alaska suicide rate and number of lives lost are based on preliminary data.*

** The 2008 US suicide rate is not yet available.*

Rate of Suicides 1998-2008

Year	Alaska Rate	Lives Lost	US Rate	Target
2008	24.6	165	0	10.6
2007	23.1	149	10.8	10.6
2006	20.1	132	10.9	10.6
2005	19.6	127	10.9	10.6
2004	23.4	154	10.9	10.6
2003	20.5	123	10.8	10.6
2002	20.9	131	10.9	10.6
2001	16.5	103	10.7	10.6
2000	21.1	135	10.4	10.6
1999	17.3	96	10.5	10.6
1998	22.7	131	11.1	10.6

Analysis of results and challenges: Alaska averages 125 suicides per year and has a suicide rate of double the national average. The Healthy Alaskan 2010 target is to reduce Alaska's suicide rate to 10.6 per 100,000. The age adjusted suicide rate for Alaska in 2008 was 24.6 per 100,000, with 165 deaths reported (2008 data is provisional and subject to change). Although Alaska experienced a dip in rates in 2005, there has been a slight increase in the suicide rate over the past four years. It is difficult to determine if these figures represent a trend or if suicide deaths occur randomly based on a variety of factors and life circumstances among those at risk of suicide. The rates have consistently risen and fallen incrementally over the past ten years. However, 2008 has shown to be one of the highest suicide rates on record. These measures reflect the need to improve Alaska's ability to provide a comprehensive and coordinated response between state agencies, Tribal entities, community providers, primary health and emergency response systems, school districts and faith-based organizations.

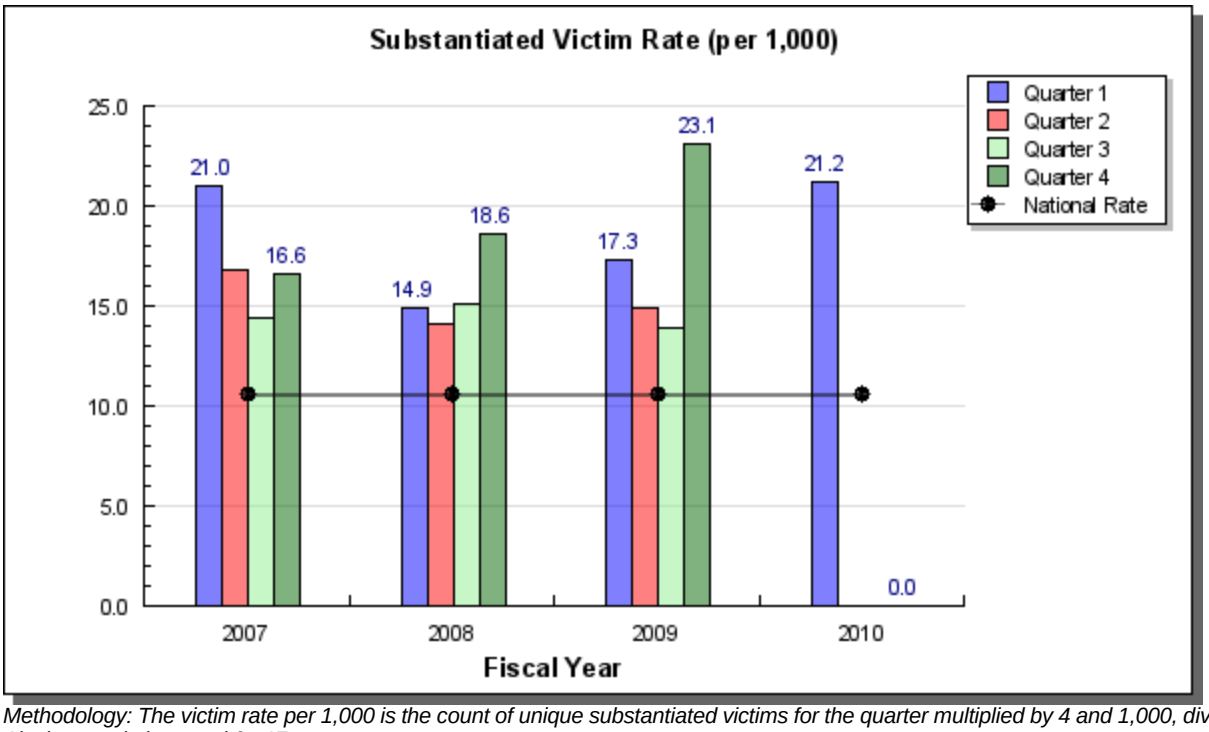
The State Suicide Prevention Council, in close working partnership with the Division of Behavioral Health, recently developed a strategic plan, implementing several strategies targeting suicide prevention awareness, outreach, and community advocacy work. The council is also working closely with the Department of Health and Social Services in an attempt to better understand the complex nature of suicide, the underlying causes, and learning prevention-based

strategies that support successful outcomes in order to begin to turn the curve away from the problem. The Division of Behavioral Health, Prevention and Early Intervention Services administers grants for comprehensive suicide prevention programs and services and provides technical training and assistance. Training topics include the Alaska Suicide Prevention Plan; community-based planning methods including identification of need, resources, readiness and capacity to provide services; understanding risk and protective factors associated with suicide in their respective community; and how to effectively collaborate with state and local partners to create a long term impact that is both sustainable and culturally competent. The Division of Behavioral Health has recently been awarded the Garrett Lee Smith Memorial Act youth suicide prevention grant and also coordinates the Alaska Gatekeeper Suicide Prevention Training program designed and targeted specifically for Alaska in order to educate and train individuals on the topic of suicide, how to respond to a suicidal person and how to direct resources to reduce risk, promote well being and improve our systems of care. These programs will be the focus of the state's efforts to combat suicide over the next few years.

Key indicator from: Department of Health and Social Services

Target: Decrease the rate of substantiated allegations of child maltreatment in Alaska.

Status: The target to decrease the rate of substantiated allegations of child maltreatment in Alaska was not met in FY09, as there was a 1.6% increase in the rate of maltreatment per 1,000 children from FY08 to FY09.



Methodology: The victim rate per 1,000 is the count of unique substantiated victims for the quarter multiplied by 4 and 1,000, divided by the Alaska population aged 0 - 17 years.

The Office of Children's Services is bringing state performance measures i n line with federal measures and methodologies. Therefore, this chart contains newly calculated measures back to Quarter 1 of 2007, and will in many cases include adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

Atypical spikes in rates may occur as a result of periodic data cleanup required in the Online Resources for the Children of Alaska (ORCA) data system and are not representative of increases in victim rates. These rate increases are manually flattened using averages as has been done with FY 2009 Quarter 1.

Source of Current Target of 10.6 - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2007.

Substantiated Victim Rate (per 1,000)

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National Rate
FY 2010	21.2	0	0	0	10.6
FY 2009	17.3	14.9	13.9	23.1	10.6
FY 2008	14.9	14.1	15.1	18.6	10.6
FY 2007	21.0	16.8	14.4	16.6	10.6

Analysis of results and challenges: An important goal of the Office of Children's Services is to protect children from maltreatment. Measuring the success of children's services agencies can be done, in part, through the number of substantiated child protective services reports received per 1,000 children under the age of 18 in the state.

In FY04, national levels of substantiated maltreatment per 1,000 children, as determined by the Administration for Children and Families, was 12. New data released for 2007 indicates national levels at 12.1. This increase represents approximately 20,000 victims nationwide.

Alaska's rate averaged 15.7% in FY08 down from 17.2% in FY07. The victim rate peaked during the 4th quarter of FY09, but as noted in the chart, the number decreased in the fist quarter of FY10.

The Office of Children's Services is continuing to perfect a new practice model. The new model has proven to be more of a paradigm shift than was previously anticipated; therefore the implementation efforts of new practice standards is taking dedicated staff time and training. The new model of working with families will lead to improved outcomes for the children and families needing OCS intervention. New practice standards have revealed that additional specialized training is necessary and is being provided through the University of Alaska and technical assistance from the federal government.

One of the fundamental differences in the new model requires workers to do an assessment of the entire family and their overall functioning and to look beyond whether the abuse or neglect is substantiated or not substantiated. In the past, workers focused just on the maltreatment itself and did not address other issues going on in the home. This resulted in missed opportunities to engage families in remedial services to avoid subsequent abuse and neglect to the child. Further, the new model helps workers to understand the essential differences in whether the child is unsafe or at risk. Unsafe determinations require OCS intervention, while risk factors may necessitate a referral to community resources. This will result in better identification of families that must be served by the child protective services system versus those that can be served by other resources.

Substance Abuse

Substance abuse affects every family and community in Alaska. Through public/private partnerships and departmental strategies DHSS will help to prevent, intervene, treat and assist recovery from substance abuse among Alaskans. Key indicators are being developed.

FY10 Current Capacity (in thousands)

Funding				Positions		
GF Funds	Federal Funds	Other Funds	Total Funds	Full Time	Part Time	Non Perm
$19,909.3	$9,946.4	$20,298.0	$50,153.7	90	0	7

Long-Term Care

Seniors are the fastest growing population in Alaska. DHSS works to determine what kinds of services are needed to keep elders at home in their communities. Strategies include developing a long-term care plan, improving services, and promoting the expansion of aging and disability resource centers.

FY10 Current Capacity (in thousands)

Funding				Positions		
GF Funds	Federal Funds	Other Funds	Total Funds	Full Time	Part Time	Non Perm
$172,783.7	$233,257.5	$31,642.8	$437,684.0	753	48	38

Key indicator from: Alaska Pioneer Homes

Target: Less than one percent medication error rate, which is one-half the low end of the

national standard range

Status: In FY09, the medication error rate decreased to .13% comparing favorably with the target medication error rate of less than one percent.

Fiscal Year Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2010	0.13%	0	0	0	0
2009	0.15%	0.10%	0.13%	0.14%	0.13%
2008	0.16%	0.13%	0.15%	0.12%	0.14%
2007	0.19%	0.22%	0.15%	0.14%	0.18%
2006	0.19%	0.15%	0.16%	0.12%	0.17%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2002	0.07%	0.08%	0.04%	0.05%	0.06%

Methodology: The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications taken by all Pioneer Home residents in the same quarter.

Analysis of results and challenges: The Centers for Medicare and Medicaid Services, which licenses nursing facilities throughout the United States, considers a five percent medication error rate acceptable.

The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the division level. In 2008, Pioneer Home staff administered an average of 488,184 individual medications each quarter.

All care processes are vulnerable to error, yet several studies have found that medication-related activities are the most frequent type of adverse event. Medication administration errors are the traditional focus of incident reporting programs because they are often the types of events that identify a failure in other processes in the system. A wrong medication may be administered because it was prescribed, transcribed, or dispensed incorrectly. The division uses a system-wide risk reporting program that tracks medication errors, and allows the collected data to be reported and trended for use in identifying risks. Trending the cause of the error tends to provide the most useful information in designing strategies for preventing future errors.

Key indicator from: Alaska Pioneer Homes

Target: Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent

Status: In FY09, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 2.7%, exceeding the 2% target rate, but in line with past performance on this measure.

Fiscal Year Sentinel Event Injury Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2010	2.3%	0	0	0	0
2009	1.3%	2.3%	3.4%	3.8%	2.7%
2008	1.5%	1.3%	2.0%	2.1%	1.73%
2007	3.5%	1.2%	2.0%	4.9%	2.9%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2004	1.96%	1.26%	0.97%	1.47%	1.45%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2002	2.9%	0.7%	0.0%	0.37%	0.99%

Methodology: The Sentinel Event Injury rate reports the percentage of falls that result in a major injury. The rate is calculated by dividing the number of Sentinel Event injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: Seventy-five percent of elderly deaths result from falls.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to

haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problems are even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older, fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

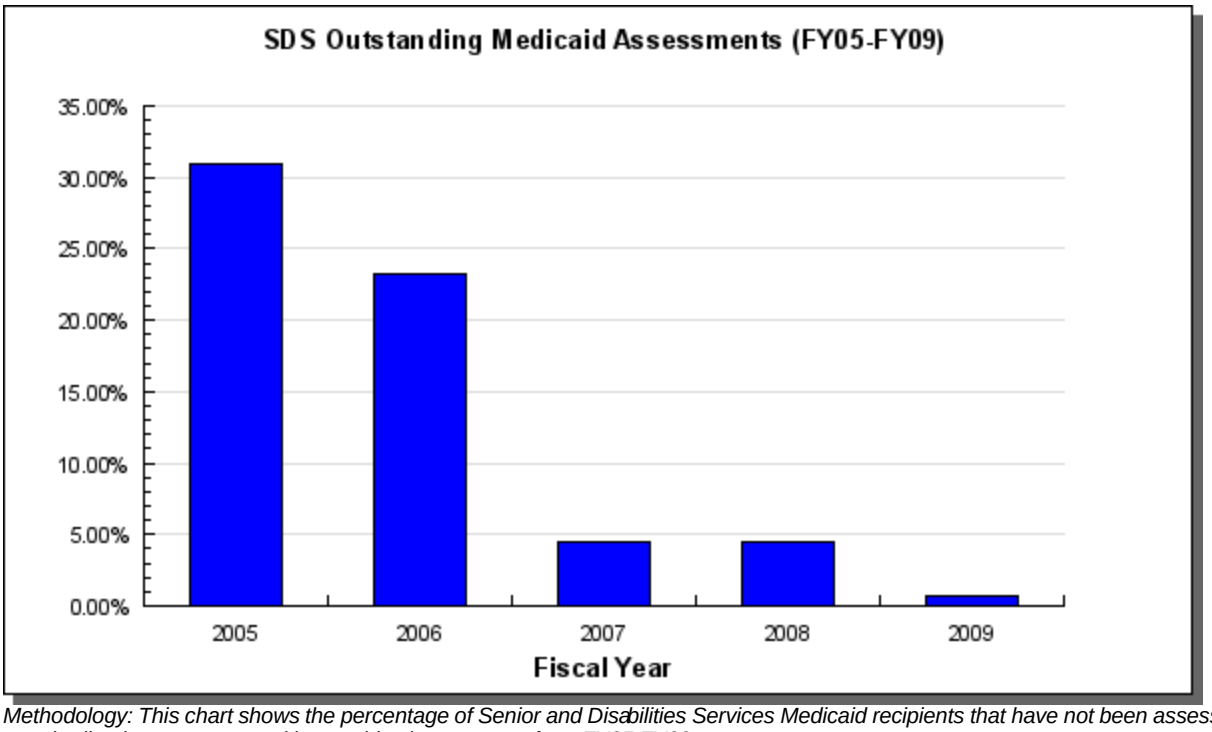
The average age of Pioneer Homes residents is 85.5, putting them in the highest risk category for suffering a serious injury from a fall that could lead to death.

The Pioneer Homes respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

Key indicator from: Senior and Disabilities Services

Target: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%.

Status: The percentage of Medicaid recipients not receiving medical assessments in FY09 was 1%, comparing favorably with the target of less than five percent.



Methodology: This chart shows the percentage of Senior and Disabilities Services Medicaid recipients that have not been assessed using a standardized assessment tool by an objective assessor from FY05-FY09.

SDS Outstanding Medicaid Assessments (FY05-FY09)

Fiscal Year	% Not Reviewed
FY 2009	.77
FY 2008	4.5%
FY 2007	4.5%
FY 2006	23.18%
FY 2005	30.9%

Analysis of results and challenges: The Personal Care Attendant (PCA) program was the only Medicaid program that did not require a state-approved medical assessment to receive services until implementation of new regulations in April of 2006. These new regulations began requiring a state-approved medical assessment and prior authorization

of Medicaid benefits to ensure that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from FY2005-2008. Senior and Disabilities Services (SDS) has worked hard to catch up on back-logged Medicaid Waiver assessments through a contractor, state staff authorized to perform assessments and through agencies with staff on-site that have the appropriate credentials to complete assessments. In spite of these efforts, there were too many pending assessments required when new regulations went into effect in April of 2006 for the Personal Care Attendant program. SDS has dramatically decreased the assessment back-log but will not be caught up until all recipients receiving PCA services have been assessed. SDS is working hard to get all assessments completed within 30 days of assignment to an assessor.

Health and Wellness

Many Alaskans lead less productive lives or die prematurely because of tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease, and sexually transmitted diseases. Strategies to combat them include prevention, access, statewide trauma system, and emergency response preparedness.

FY10 Current Capacity (in thousands)

Funding				Positions		
GF Funds	Federal Funds	Other Funds	Total Funds	Full Time	Part Time	Non Perm
$234,172.0	$522,583.4	$34,523.1	$791,278.5	606	15	18

Key indicator from: Department of Health and Social Services

Target: 80% of all 2 year olds are fully immunized.

Status: In 2007, 70% of two year olds were fully immunized, which was below the 80% target rate, but slightly above the 67% in FY06. Alaska ranked 45th in the country for fully immunized two year olds.

Vaccination Coverage Among Children 19-35 Months of Age, Alaska and US

Year	US %	Alaska %	AK US Rank
2007	77.4	70.1*	45
2006	77.0	67.3*	47
2005	76.1	68.1*	41
2004	80.9	75.3	45
2003	79.4	79.7	27
2002	74.8	75.3	30
2001	73.7	71.2	35
2000	72.8	70.6	41
1999	73.2	74.5	27

Methodology: In 2005, CDC began using a new six-dose standard for its recommended basic immunization series.

Analysis of results and challenges: Chart Note: Source - National Immunization Survey, Centers for Disease Control and Prevention. Annual percentages are based on CDC recommendations at the time, which have changed over the years as vaccines have been added to the "basic immunization series."

* In 2005, the CDC increased its recommendation to a new, six-dose series of vaccinations. As a result, the national rate of fully immunized two year olds dropped considerably, as did Alaska's rate. These results continue to illustrate the need for renewed emphasis on the importance of timely immunizations for young children.

Key indicator from: Public Health

Target: 95% of persons with tuberculosis (TB) will complete adequate treatment within one year of beginning treatment

Status: In 2007, 90% of persons with tuberculosis (TB) completed adequate treatment; this was in line with prior year performance. This was below the target rate of 95% primarily due to some difficult cases.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2008	N/A*
2007	90%
2006	90%
2005	92%
2004	86%
2003	93%
2002	93%

*Methodology: *TB treatment requires 6-9 months for completion. Some 2008 cases are still being treated.*

Analysis of results and challenges: The highest priority for TB control is to ensure that persons with the disease are diagnosed early and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. However, some TB patients are difficult to locate, are noncompliant or have medical complications that don't allow them to receive full treatment within the allotted time period. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

Key indicator from: Public Health

Target: Reduce Alaska's unintentional injury death rate to 50/100,000 population

Status: The 2007 death rate caused by unintentional injuries was 57.3 per 100,000 population, above the 50/100,000 target and representing a nearly 10% increase from the 2006 rate. The rate dropped by 12% from 2002 to 2006.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
2007	57.3 +9.98%	N/A
2006	52.1 +2.96%	N/A
2005	50.6 -8%	39.7 +4.2%
2004	55.0 -0.54%	38.1 +1.33%
2003	55.3 -6.59%	37.6 +1.62%
2002	59.2 -3.11%	37.0 +3.64%
2001	61.1 -4.38%	35.7 +2.59%
2000	63.9 +11.13%	34.8 -0.85%
1999	57.5	35.1

Methodology: U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

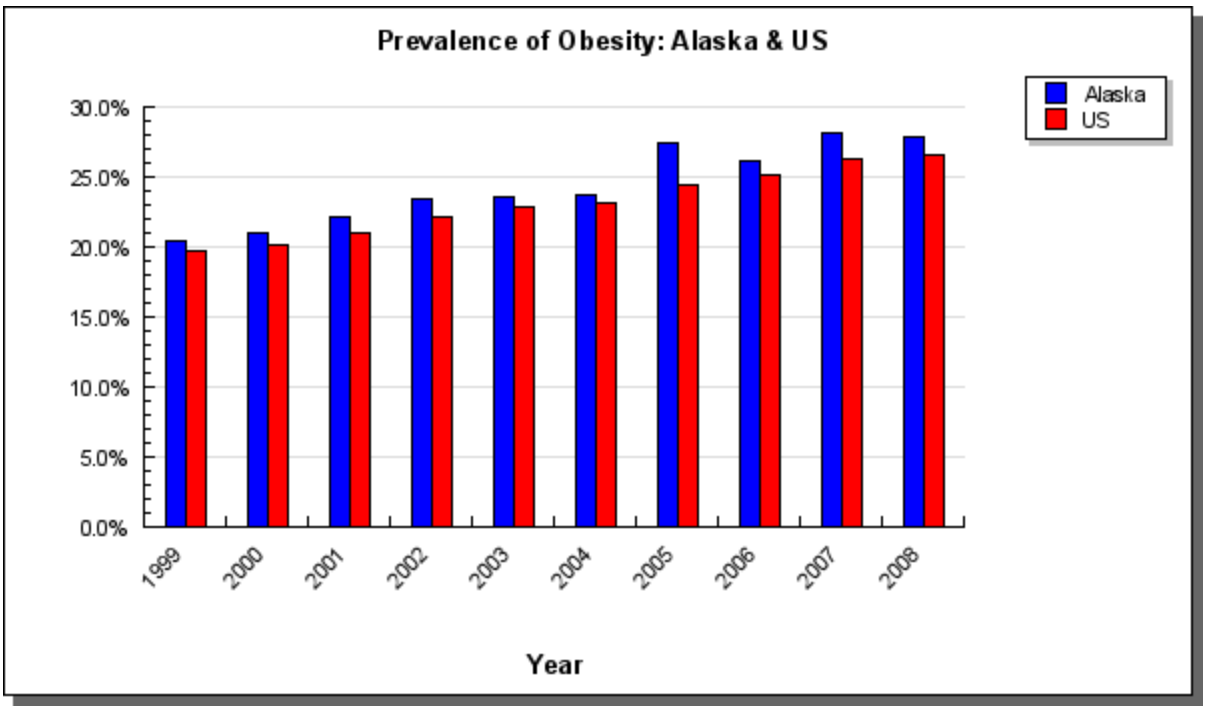
Analysis of results and challenges: Injuries are a significant public health and social services problem because of Alaska's high prevalence, the toll on the young and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries. Unintentional injuries are the third leading cause of death in Alaska. Cancer and heart disease are the leading causes of death among the elderly, but injuries are the leading cause of death in children and young adults.

The Division of Public Health along with its many partners continues to see the benefits of actions related to injury control and prevention. The Safe Boating Act and Kids Don't Float programs are two examples of successful activities. DPH's Injury Control program will continue to partner with others and to use data analysis and prevention strategies to understand and target interventions.

Key indicator from: Department of Health and Social Services

Target: Decrease Alaska's adult obesity rate to less than 18%.

Status: The adult obesity rate was 27.9% in 2008, below the 28.2% in 2007. However, this was higher than the 26.6% national average and did not meet the 18% target rate.



Prevalence of Obesity: Alaska & US

Year	Alaska	US
2008	27.9%	26.6%
2007	28.2%	26.3%
2006	26.2%	25.1%
2005	27.4%	24.4%
2004	23.7%	23.2%
2003	23.6%	22.8%
2002	23.4%	22.1%
2001	22.1%	21%
2000	21.0%	20.1%
1999	20.4%	19.7%

Analysis of results and challenges: Chart Note: Sources – Alaska and U.S. Behavioral Risk Factor Surveillance System; crude rates.

The trends in Alaska continue to show growing numbers of overweight and obese adults, with an obesity prevalence at 27.9% in 2008 - an alarming 30% higher than the 1999 Alaska prevalence level and 55% higher than the Healthy Alaskans 2010 target.

Premature death and disability, increased heath care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with inactivity are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States. Alaskans annually spend $477 million on obesity-related direct medical expenditures.

Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Obesity is a health threat to all generations of Alaskans, and threatens to make this generation the first to live shorter lives than their parents. It increases the risks of chronic diseases and conditions such as heart disease, diabetes, stroke,

hypertension, some cancers, and premature death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

A comprehensive approach, as identified in Alaska in Action: the Statewide Physical Activity and Nutrition Plan, is needed to decrease obesity in Alaska. Through educational, programmatic, policy, and environmental strategies, the department works to reduce the percentage of Alaskans classified as overweight or obese.

Key indicator from: Department of Health and Social Services

Target: Reduce post-neonatal death rate to 2.3 per 1,000 live births by Healthy Alaskans 2010.

Status: The post-neonatal death rate for 2008 was 3.0 per 1,000 live births, above the target of 2.3 per 1,000 live births, but below the rate of 3.3 per 1,000 in 2007.

Post-Neonatal Death Rate - AK and US

Year	Alaska	US
2008	3.0	NA
2007	3.3	NA
2006	3.2	2.3
2005	2.8	2.3
2004	3.2	2.3
2003	3.8	2.2
2002	3.6	2.3
2001	4.5	2.3
2000	3.2	2.3
1999	3.0	2.3

Analysis of results and challenges: Chart Note: Rate per 1,000 live births reflects three-year rate, i.e. 2008 represents 2006-2008.

Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the three leading causes of death during the post-neonatal period (28 through 364 days) in 2005 were birth defects, short gestation/low birthweight, and Sudden Infant Death Syndrome (SIDS) , In Alaska, SIDS/asphyxia is a contributing factor in half of all post-neonatal deaths. Other primary causes are birth defects and infection. The post-neonatal mortality rate in Alaska is higher than the national target of 2.3 per 1,000 live births (Healthy People 2010) and has remained relatively static over time. While not shown graphically, over the last decade Alaska Native infants were twice as likely to die during the post-neonatal period than non-Native infants.

Work by DHSS is underway with the Indian Health Service on a rural initiative to prevent Sudden Infant Death Syndrome (SIDS). Cessation efforts involving tobacco, alcohol and other drugs are being targeted on the pre-conception and prenatal periods. DHSS is launching a statewide Infant Safe Sleep Project to reduce infant death, and a task force will convene in Fall 2009. Finally, work has begun with health providers and community partners to establish a model program of early prevention and chronic disease management for prenatal patients.

Key indicator from: Public Health

Target: Less than 17% of high school youth in Alaska smoke

Status: There has been a 51% decline in youth smoking over 12 years, bringing the 2007 prevalence rate of 18% within 1 percentage point of the 17% target.

Prevalence of cigarette smoking in Alaska youth in past 30 days (per YRBS survey)

Year	Alaska	US
2007	17.8	20.0 -13.04%
2005	NA	23.0 +5.02%
2003	19.2	21.9 -23.16%
2001	NA	28.5 -18.1%
1999	NA	34.8

Methodology: Data is collected every other year. Alaska data not released in years when a statistically valid sample is not available. U.S. data will be reported when released by the CDC.

Analysis of results and challenges: Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking, being overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening. Smokers' risk of heart attack is more than twice that of nonsmokers. Chronic exposure to environmental tobacco smoke (second-hand smoke) also increases the risk of heart disease. Cigarette smoking is also an important risk factor for stroke.

Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.2% in 2003 and 17.8% in 2007. Data are available from the Youth Risk Behavior Survey when enough Alaska schools participate to give results that can be generalized to the high school population as a whole in the state. This was the case only in 1995, 2003 and 2007. Surveys occurred in other years; however, schools did not have enough participants to provide statewide results. It is the goal of the Division of Public Health to continue to work with schools to collect a representative sample every other year.

The Healthy Alaskans 2010 target is 17.0%.

Health Care Reform

Alaska's health care system continues to be fragmented. Major strategies to improve the system include care management, Medicaid reform, creation of a Health Care Commission to identify and develop a state action plan, and growing the health care workforce.

FY10 Current Capacity (in thousands)

Funding				Positions		
GF Funds	Federal Funds	Other Funds	Total Funds	Full Time	Part Time	Non Perm
$3,392.8	$4,098.4	$657.5	$8,148.7	30	0	2

Key indicator from: Health Care Services

Target: Increase funds recovered by 2%.

Status: From FY08 to FY09 the Division of Health Care Services realized an increase in GF recovery of 14%, exceeding the 2% target increase.

Medicaid Recoveries: Drug Rebates & Third Party Liability (TPL) Collections (in millions)

Year	Drug Rebates	TPL	Total	% Change
2009	24.0	10.2	34.2	14%
2008	21.6	8.4	30.0	0%
2007	15.5	14.5	30.0	19%
2006	27.5	9.4	36.9	5%
2005	30.2	8.7	38.9	32%
2004	19.4	10.1	29.5	18%
2003	17.0	8.0	25.0	N/A

Analysis of results and challenges: Overall TPL collections for Health Care Services increased approximately 14% between FY08 and FY09. However, there was no overall increase in collections during FY08. The increase in recoveries experienced during FY09 can be attributed to a number of contributing factors, among them increased receipts recovered by the TPL contractor, increased subrogation recoveries, and more stringent application of Medicare eligibility.

Key indicator from: Health Care Services

Target: Increase Indian Health Services (IHS) Medicaid participation by 5% in expenditures.

Status: Indian Health Services (IHS) Medicaid participation increased by 9% in expenditures from FY08 to FY09. This exceeded the 5% target increase.

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2009	$573.4	159.3	28%	9%
FY 2008	$517.9	$146.3	28%	9%
FY 2007	$490.2	$134.2	27%	-14%
FY 2006	$528.9	$155.6	29%	-12%
FY 2005	$558.2	$177.8	32%	15%
FY 2004	$503.6	$154.5	31%	15%
FY 2003	$466.6	$134.9	29%	51%
FY 2002	$385.9	$89.3	23%	22%
FY 2001	$323.0	$73.3	23%	48%
FY 2000	$268.4	$49.4	18%	32%
FY 1999	$228.6	$37.5	16%	98%

Methodology: Total expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

The % increase is the percent change in IHS expenditures from the prior year.

DHSS, FMS, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: Indian Health Service (IHS) expenditures increased from FY08 to FY09 by $13 million. The increase can be attributed to increased IHS claim filing, increased use of IHS facilities, and adjustments in encounter rates following facility rate reviews.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation, whereas non-IHS facility patient costs require a state match of GF funds on expenditures.

Background:

Increased IHS billing capacity by tribal entities assists with revenue generation. This directly contributes to tribal entities being able to maintain and hire staff to serve recipients closer to home on a more consistent basis. It also decreases the number of American Indian/Alaska Native (AI/AN) beneficiaries going to non-tribal facilities. Certain tribal entities with 638 status receive 100% FMAP for service delivery to AI/AN beneficiaries, thus assisting the state with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the

Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that AI/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an AI/AN beneficiary is connected to a tribal healthcare delivery system that is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door beneficiaries enter, for example, whether it's behavioral health, clinic, or dental, they become a part of the larger tribal healthcare delivery system of that region. The more revenue they generate per service category, the more consistent the long-term system becomes.

Alaska Pioneer Homes Results Delivery Unit

Mission

Provide the highest quality of life in a safe home environment for older Alaskans and Veterans.

Core Services

- Provide residential assisted living services.

End Result	Strategies to Achieve End Result
A: Eligible Alaskans and Veterans live in a safe environment. Target #1: Reduce resident serious injury rate Status #1: In FY09, the medication error rate decreased to .13% while medications administered increased to an average of 499,366 per fiscal quarter, up from 434,464 in FY06. In FY09, our sentinel event injury rate from falls decreased to 2.7%, down from 2.9% in FY07.	**A1: Improve the medication dispensing and administration system.** Target #1: Less than one percent medication error rate, which is one-half the low end of the national standard range Status #1: In FY09, the medication error rate decreased to .13% comparing favorably with the target medication error rate of less than one percent. **A2: Reduce the number of residents' serious injuries from falls.** Target #1: Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent Status #1: In FY09, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 2.7%, exceeding the 2% target rate, but in line with past performance on this measure.

Performance Detail

A: Result - Eligible Alaskans and Veterans live in a safe environment.

Target #1: Reduce resident serious injury rate
Status #1: In FY09, the medication error rate decreased to .13% while medications administered increased to an average of 499,366 per fiscal quarter, up from 434,464 in FY06.
In FY09, our sentinel event injury rate from falls decreased to 2.7%, down from 2.9% in FY07.

Analysis of results and challenges: Increasing age and acuity levels of Pioneer Homes residents creates a challenge in reducing adverse events that result in serious injury. By properly utilizing the strength of trending and tracking information available in the division's risk analysis program, the Homes are able to identify times, places, individual staff and conditions that hold inherent risk. Action plans to address risk help the Homes prevent errors, reduce the number of serious injury events, and reduce the severity of injury.

A1: Strategy - Improve the medication dispensing and administration system.

Target #1: Less than one percent medication error rate, which is one-half the low end of the national standard range
Status #1: In FY09, the medication error rate decreased to .13% comparing favorably with the target medication error rate of less than one percent.

Fiscal Year Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2010	0.13%	0	0	0	0
2009	0.15%	0.10%	0.13%	0.14%	0.13%
2008	0.16%	0.13%	0.15%	0.12%	0.14%
2007	0.19%	0.22%	0.15%	0.14%	0.18%
2006	0.19%	0.15%	0.16%	0.12%	0.17%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2002	0.07%	0.08%	0.04%	0.05%	0.06%

Methodology: The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications taken by all Pioneer Home residents in the same quarter.

Analysis of results and challenges: The Centers for Medicare and Medicaid Services, which licenses nursing facilities throughout the United States, considers a five percent medication error rate acceptable.

The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the division level. In 2008, Pioneer Home staff administered an average of 488,184 individual medications each quarter.

All care processes are vulnerable to error, yet several studies have found that medication-related activities are the most frequent type of adverse event. Medication administration errors are the traditional focus of incident reporting programs because they are often the types of events that identify a failure in other processes in the system. A wrong medication may be administered because it was prescribed, transcribed, or dispensed incorrectly. The division uses a system-wide risk reporting program that tracks medication errors, and allows the collected data to be reported and trended for use in identifying risks. Trending the cause of the error tends to provide the most useful information in designing strategies for preventing future errors.

A2: Strategy - Reduce the number of residents' serious injuries from falls.

Target #1: Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent

Status #1: In FY09, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 2.7%, exceeding the 2% target rate, but in line with past performance on this measure.

Fiscal Year Sentinel Event Injury Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2010	2.3%	0	0	0	0
2009	1.3%	2.3%	3.4%	3.8%	2.7%
2008	1.5%	1.3%	2.0%	2.1%	1.73%
2007	3.5%	1.2%	2.0%	4.9%	2.9%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2004	1.96%	1.26%	0.97%	1.47%	1.45%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2002	2.9%	0.7%	0.0%	0.37%	0.99%

Methodology: The Sentinel Event Injury rate reports the percentage of falls that result in a major injury. The rate is calculated by dividing the number of Sentinel Event injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: Seventy-five percent of elderly deaths result from falls.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problems are even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older, fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than

other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

The average age of Pioneer Homes residents is 85.5, putting them in the highest risk category for suffering a serious injury from a fall that could lead to death.

The Pioneer Homes respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

Behavioral Health Results Delivery Unit

Mission

Manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.

Core Services

- Provide for a continuum of statewide mental health and substance use disorder services ranging from prevention, early intervention, treatment, and recovery, including inpatient psychiatric hospitalization and operation of the Alaska Psychiatric Institute.

End Result	Strategies to Achieve End Result
A: The quality of life for Alaskans experiencing a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance use disorder (SUD) is enhanced. Target #1: For each of six life domains (financial/basic needs, housing situation, meaningful activities/employment, mental/emotional health, physical health, and thoughts of self harm), 75% of individuals will report improvement or maintaining condition. Status #1: In FY09, for each of three life domains (housing situation, physical health, and thoughts of self harm), more than 75% of individuals who received services through the comprehensive, integrated Behavioral Health Service System reported improvement or maintaining condition. For each of the remaining three life domains (financial/basic needs, meaningful activities/employment, and mental/emotional health), less than 75% of individuals reported improvement or maintaining condition.	**A1: Improve and enhance the quality of life of children experiencing a serious emotional disturbance through treatment services that meet their clinical needs close to their home communities.** Target #1: Reduce the number of children in out-of-state residential psychiatric treatment centers (RPTCs) by 10% each year. Status #1: From FY07 to FY08, there was a 19.8% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care. **A2: Improve and enhance the quality of life of Alaskans experiencing a SED, a SMI and/or a SUD by implementing a Performance Management System that promotes process improvement and fosters partnerships to improve the quality of services provided.** Target #1: 75% of individuals (including adults, parents/caregivers of youth, and teens) who complete the Annual Behavioral Health Consumer Survey will report a positive overall evaluation of services. Status #1: In FY09, 77% of the Annual Behavioral Health Consumer Survey adult and teen respondents reported a positive overall evaluation of services; 79% of parents/caregivers of youth reported a positive overall evaluation of services. **A3: Improve and enhance the quality of life of Alaskans experiencing a SED, a SMI and/or a SUD by assuring them access to a comprehensive, integrated Behavioral Health Service System.** Target #1: Increase annually by 2.5% the number of enrollments into serious behavioral health disorder programs (i.e., serious emotional disturbance (SED), serious mental illness (SMI), and substance use disorder (SUD) programs).

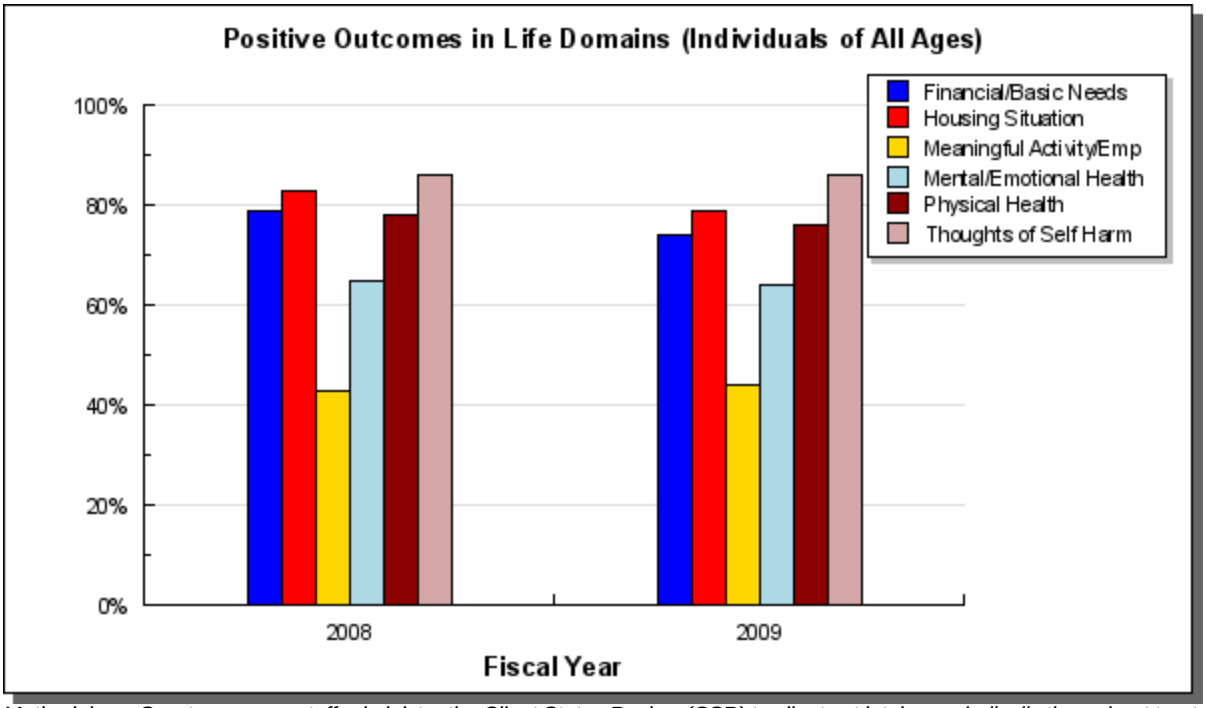
	Status #1: From FY08 to FY09, the reported number of enrollments into serious behavioral health disorder programs increased more than 20% for SED, SMI, and SUD programs.

Performance Detail

A: Result - The quality of life for Alaskans experiencing a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance use disorder (SUD) is enhanced.

Target #1: For each of six life domains (financial/basic needs, housing situation, meaningful activities/employment, mental/emotional health, physical health, and thoughts of self harm), 75% of individuals will report improvement or maintaining condition.

Status #1: In FY09, for each of three life domains (housing situation, physical health, and thoughts of self harm), more than 75% of individuals who received services through the comprehensive, integrated Behavioral Health Service System reported improvement or maintaining condition. For each of the remaining three life domains (financial/basic needs, meaningful activities/employment, and mental/emotional health), less than 75% of individuals reported improvement or maintaining condition.



Methodology: Grantee agency staff administer the Client Status Review (CSR) to clients at intake, periodically throughout treatment, and at time of discharge. A client's status of "improvement or maintaining condition" is determined based on comparing CSR scores from the most recent CSR to the intake CSR. Note: The CSR is not required for clients receiving psychiatric emergency services and/or detoxification services.

Data Source Date: August 2009

Positive Outcomes in Life Domains (Individuals of All Ages)

Fiscal Year	Financial/Basic Needs	Housing Situation	Meaningful Activity/Emp	Mental/Emotional Health	Physical Health	Thoughts of Self Harm
FY 2009	74%	79%	44%	64%	76%	86%
FY 2008	79%	83%	43%	65%	78%	86%

Analysis of results and challenges: In FY09, for each of three life domains (housing situation, physical health, and thoughts of self harm), more than 75% of individuals reported improvement or maintaining condition. For each of the

remaining three life domains (financial/basic needs, meaningful activities/employment, and mental/emotional health), less than 75% of individuals reported improvement or maintaining condition.

FY08 was a baseline year. From FY08 to FY09, the percent of clients who reported improvement or maintaining condition for each of the six life domains changed only slightly. The most significant of these slight changes were in the financial/basic needs and housing situation domains:

-- Positive outcomes in the financial/basic needs domain decreased from 79% in 2008 to 74% in 2009 (this is just below the target value of 75%).

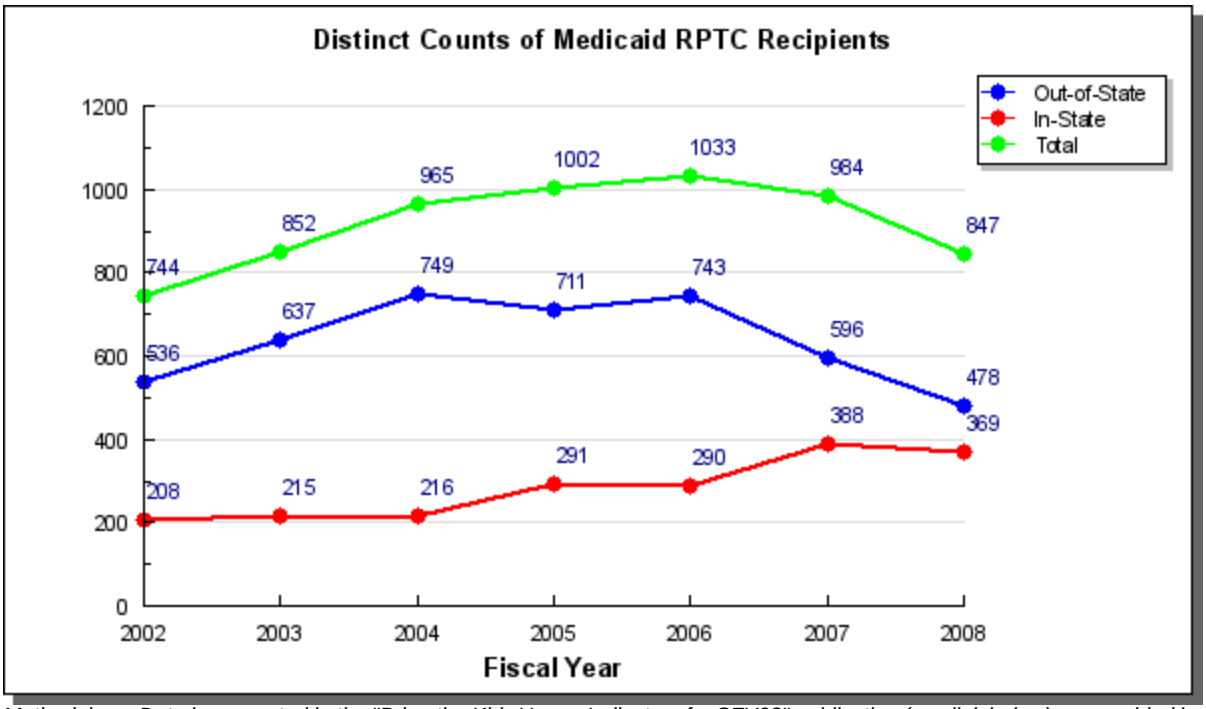
-- Positive outcomes in the housing situation domain decreased from 83% in 2008 to 79% in 2009.

In both FY08 and FY09, the life domains with the lowest percentage of individuals reporting improvement or maintaining condition were meaningful activities/employment (43% in FY08 and 44% in FY09) and mental/emotional health (65% in FY08 and 64% in FY09).

The CSR instrument is currently under revision to improve its usefulness in assessing change over time. This revision will include a child version. The target date for implementing the new CSR instruments (adult and child) is July 1, 2010. In addition, refinements to the CSR reporting procedures are being explored to report change over time for various client groups (e.g., type of services received, duration of services received, and demographic characteristics).

A1: Strategy - Improve and enhance the quality of life of children experiencing a serious emotional disturbance through treatment services that meet their clinical needs close to their home communities.

Target #1: Reduce the number of children in out-of-state residential psychiatric treatment centers (RPTCs) by 10% each year.
Status #1: From FY07 to FY08, there was a 19.8% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care.



Methodology: Data is presented in the "Bring the Kids Home: Indicators for SFY08" publication (see link below), as provided by the Division of Behavioral Health, Policy and Planning Section (data source: MMIS). The In-State and Out-of-State RPTC recipient counts are each unduplicated; the Total RPTC recipient count is duplicated between In-State and Out-of-State.

** Data for the "Bring the Kids Home: Indicators for SFY09" are not yet available.*

Distinct Counts of Medicaid RPTC Recipients

Fiscal Year	Out-of-State	In-State	Total
FY 2008	478	369	847
FY 2007	596	388	984
FY 2006	743	290	1033
FY 2005	711	291	1002
FY 2004	749	216	965
FY 2003	637	215	852
FY 2002	536	208	744

Analysis of results and challenges: The Bring the Kids Home (BTKH) Project was initiated during FY04. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice, and Office of Children's Services, in partnership with the Alaska Mental Health Trust Authority. Positive changes are apparent as shown by the significant reduction, since FY04, in the number of youth experiencing serious emotional disorders receiving care in out-of-state RPTCs.

From FY04 to FY08, there was a 36.2% decrease in the number of out-of-state RPTC recipients of care (749 in FY04; 478 in FY08) and a 70.8% increase in the number of in-state RPTC recipients of care (216 in FY04; 369 in FY08). In addition, for the same time period, the total RPTC recipient count decreased by 12.2% (965 in FY04; 847 in FY08). The total RPTC recipient count peaked in FY06. Since then, there has been an 18% decrease in the total RPTC recipient count (1,033 in FY06; 847 in FY08). These shifts reflect a number of capital projects initiated to increase the number of beds in-state, some of which became available in FY07. In addition, there have been capacity expansion grants to community providers to enhance the service continuum for children and families that provide services at the least restrictive level within a client's home community. As more new beds and other programs become available, it is anticipated that there will be further impact on the number of out-of-state RPTC recipients of care.

Annual comparisons from FY06 to FY08:

From FY07 to FY08 there was a:
- 19.8% decrease in the number of distinct out-of-state RPTC recipients of care.
- 4.9% decrease in the number of distinct in-state RPTC recipients of care.
- 13.9% decrease in the total RPTC recipient count.

From FY06 to FY07 there was a:
- 19.8% decrease in the number of distinct out-of-state RPTC recipients of care.
- 33.8% increase in the number of distinct in-state RPTC recipients of care.
- 4.7% decrease in the total RPTC recipient count.

From FY98 to FY04, the number of distinct out-of-state RPTC recipients of care steadily increased – on average, 46.7% per year. Also, for the same time period, the total RPTC recipient count steadily increased - on average 24.8% per year.

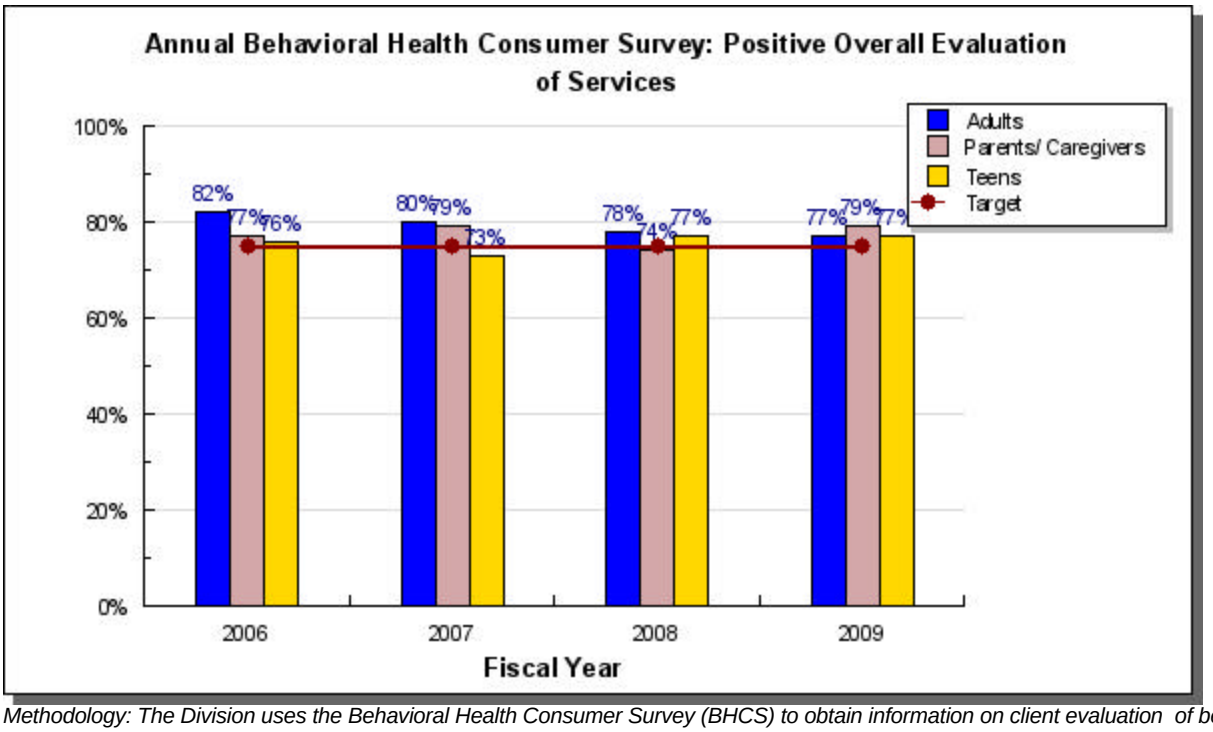
AS47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the department has developed and implemented "diversion" activities, including aggressive case management services that discharge and return children to less restrictive levels of care; utilization review staff implementing gate-keeping protocols with a "level of care" instrument that ensures appropriate placements; and assertive case management with Individualized Service Agreements which direct funding to community-based providers who augment services at the least restrictive level within a client's home community.

A2: Strategy - Improve and enhance the quality of life of Alaskans experiencing a SED, a SMI and/or a SUD by implementing a Performance Management System that promotes process improvement and fosters partnerships to improve the quality of services provided.

Target #1: 75% of individuals (including adults, parents/caregivers of youth, and teens) who complete the Annual Behavioral Health Consumer Survey will report a positive overall evaluation of services.

Status #1: In FY09, 77% of the Annual Behavioral Health Consumer Survey adult and teen respondents reported a

positive overall evaluation of services; 79% of parents/caregivers of youth reported a positive overall evaluation of services.



Methodology: The Division uses the Behavioral Health Consumer Survey (BHCS) to obtain information on client evaluation of behavioral health services. Grantee agencies mail the Annual BHCS to clients receiving outpatient treatment services; surveys are returned to the Division for processing.

Annual Behavioral Health Consumer Survey: Positive Overall Evaluation of Services

Fiscal Year	Adults	Parents/ Caregivers	Teens
FY 2009	77%	79%	77%
FY 2008	78%	74%	77%
FY 2007	80%	79%	73%
FY 2006	82%	77%	76%

Analysis of results and challenges: In FY09, 77% of the Annual Behavioral Health Consumer Survey (BHCS) adult and teen respondents reported a positive overall evaluation of services; 79% of parents/caregivers of youth reported a positive overall evaluation of services.

From FY06 to FY09 there was some fluctuation in respondents' evaluation of services. FY08 is considered to be a new baseline year due to survey methodology changes implemented for the FY08 BHCS.

From FY08 to FY09, the percent of adults and teens who reported a positive overall evaluation of services remained almost the same:

--Adults: FY08 = 78%; FY09 = 77%
--Teens: FY08 = 77%; FY09 = 77%

From FY08 to FY09, the percent of parents/caregivers of youth who reported a positive overall evaluation of services increased several percentage points:

--Parents/Caregivers of Youth: FY08 = 74%; FY09 = 79%
(Due to the relatively small sample size of parent/caregiver respondents, this difference is only marginally significant.)

The Division continues to refine the BHCS administration process to improve accuracy, completeness, and response

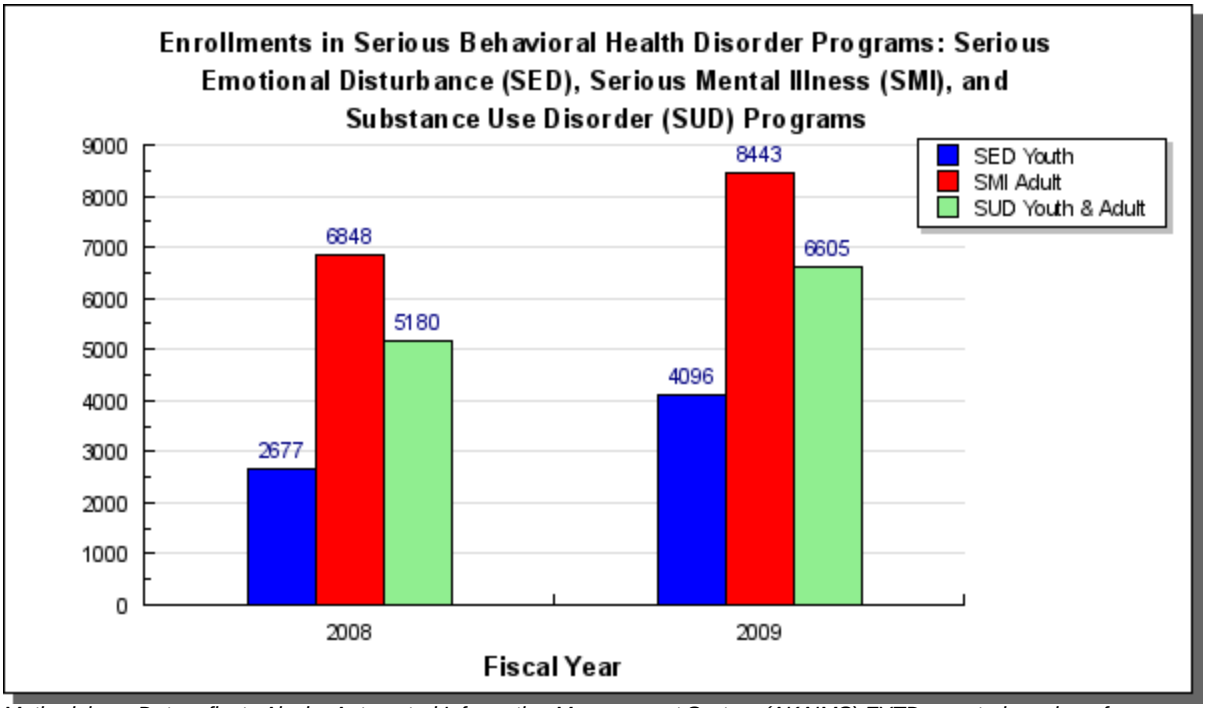
rate.

The Division also is making progress in implementing its Performance Management System. Performance Based Funding measures were developed and applied to funding allocations to service providers for FY09 and FY10. Participation in administering the BHCS was one of several performance measures used to determine funding allocations.

A3: Strategy - Improve and enhance the quality of life of Alaskans experiencing a SED, a SMI and/or a SUD by assuring them access to a comprehensive, integrated Behavioral Health Service System.

Target #1: Increase annually by 2.5% the number of enrollments into serious behavioral health disorder programs (i.e., serious emotional disturbance (SED), serious mental illness (SMI), and substance use disorder (SUD) programs).

Status #1: From FY08 to FY09, the reported number of enrollments into serious behavioral health disorder programs increased more than 20% for SED, SMI, and SUD programs.



Methodology: Data reflects Alaska Automated Information Management System (AKAIMS) FYTD reported number of program enrollments. Program enrollments are not an unduplicated count of individuals served; one person may be enrolled in several programs.

FY 2008 Data Source Date: November 2008
FY 2009 Data Source Date: August 2009

Enrollments in Serious Behavioral Health Disorder Programs: Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), and Substance Use Disorder (SUD) Programs

Fiscal Year	SED Youth	SMI Adult	SUD Youth & Adult	Total
FY 2009	4096 +53.01%	8443 +23.29%	6605 +27.51%	19,144 +30.19%
FY 2008	2677	6848	5180	14,705

Analysis of results and challenges: In order to improve and enhance the quality of life of Alaskans who experience a behavioral health problem, access to a comprehensive, integrated service system is critical. Measuring treatment services through program enrollments is an effective method to measure accessibility of services.

This measurement reports the level at which Alaskans are accessing services, as well as the efforts to improve statewide data collection. FY08 was a baseline year for reporting program enrollments using the Alaska Automated

Information Management System (AKAIMS). During FY08, numerous grantee agencies struggled with data submission requirements and were not able to enter all client records into AKAIMS. Therefore, FY08 program enrollments are under-reported. The Division's efforts to assist grantee providers with technical assistance and reporting performance based measures specific to data completeness has greatly improved the AKAIMS data collection, analysis and reporting capabilities. The FY09 reported number of enrollments reflects a significant improvement toward complete electronic health records from grantee agencies.

During FY09, the behavioral health system of care provided 4,096 enrollments in Severely Emotionally Disturbed (SED) programs, 8,443 enrollments in Severely Mentally Ill (SMI) programs, and 6,605 enrollments in substance use disorders (SUD) programs, for a total of 19,144 program enrollments. Program enrollments are not an unduplicated count of individuals served, as one person may be enrolled in several programs.

Improvements in data collection have resulted in greater measurement of program enrollments.
From FY08 to FY09:

- The reported number of SED program enrollments increased 53.0% from 2677 in FY08 to 4096 in FY09.
- The reported number of SMI program enrollments increased 23.3% from 6848 in FY08 to 8443 in FY09.
- The reported number of SUD program enrollments increased 27.5% from 5180 in FY08 to 6605 in FY09.

The Division, in conjunction with the Mental Health Trust and Advisory Boards, completed the 2006 Alaska prevalence estimates of serious behavioral health disorders. These prevalence estimates will be used as a benchmark to measure penetration rates of behavioral health services. Based on the 2006 census data for low income households, there was an estimated 28,684 Alaskans experiencing a serious behavioral health disorder (i.e., SED, SMI, SUD, or both SMI and SUD). In comparison, for all households, there was an estimated 51,430 Alaskans experiencing a serious behavioral health disorder. For details, refer to the Division's "2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household" (see link below). These estimates, which are considered to be conservative, provide a basis for identifying unmet needs in Alaska's low income and total household population.

The "2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household" is available at the following link in the Document Library:

https://dbh-ssweb.state.ak.us/sites/COSIG/outcomes/default.as

Children's Services Results Delivery Unit

Mission

Promote safe children and strong families.

Core Services

- Investigate protective service reports and ensure services to children and their families when necessary.
- Develop case plans and monitor progress of in-home services.
- Develop permanency plans for children in out-of-home care.
- Facilitate early intervention and treatment services.
- Prevent and remedy child abuse and neglect.

End Result	Strategies to Achieve End Result
A: Child abuse and neglect is prevented. Target #1: Increase the number of Early Intervention/Infant Learning Program screenings for children age 0-3 to meet federal requirements. Status #1: The number of children aged 0 - 3 that have been screened through the Early Intervention and Infant Learning Programs has more than tripled in the past 4 years. In FY03, 113 children were screened. In FY08, 425 children were screened. That number decreased by 11% in FY09.	**A1: Increase the number of referrals from Children's Protective Services to Early Intervention/Infant Learning Program services.** Target #1: Increase the percentage of child protection services referrals provided to children ages 0-3 and attain federal compliance. Status #1: Child Protective Services referrals completed by the Early Intervention and Infant Learning programs have increased 55% from 2003 to 2008. Numbers fell by only 1% in FY09. **A2: To reunify children in out-of-home placements with parents or caretakers as soon as it is safe to do so.** Target #1: Increase the rate of children reunified with their parents or caretakers within 12 months of removal. Status #1: Annual rates of all children reunified with their parents or caretakers within 12 months of removal dropped by 5.5% in FY09. The first quarter of FY10 remains at 61%.

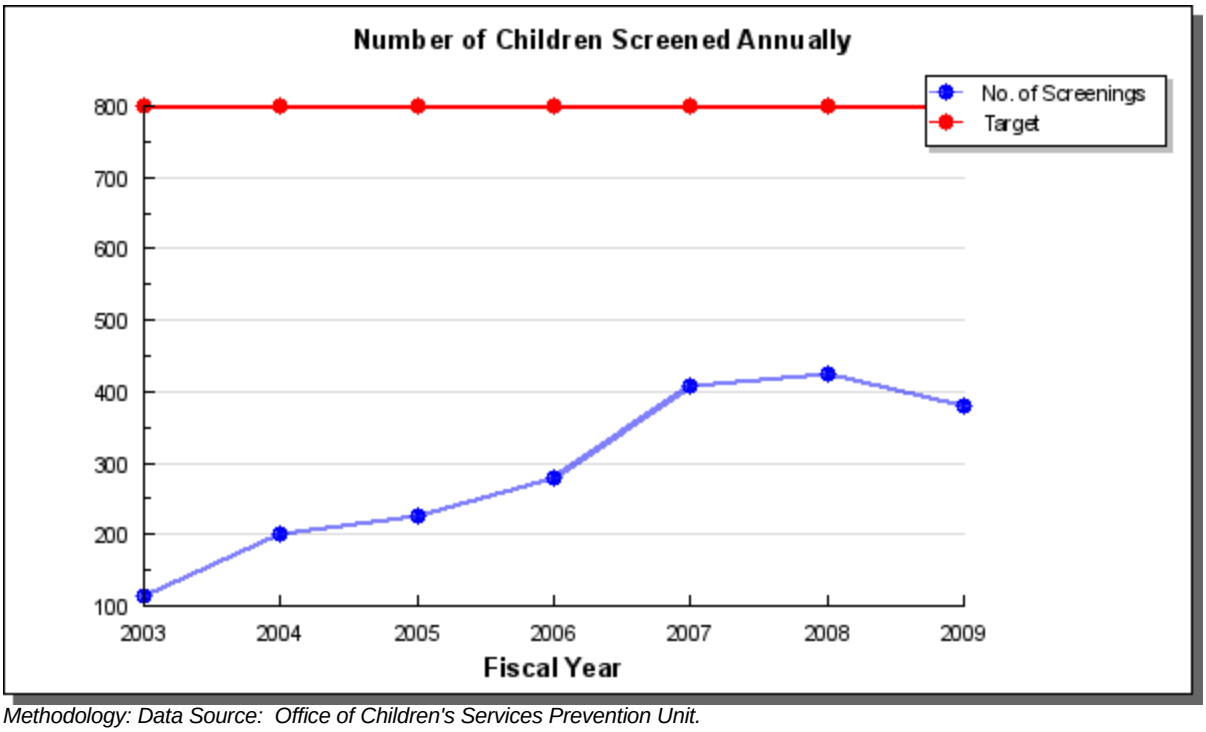
End Result	Strategies to Achieve End Result
B: Safe and timely adoptions. Target #1: Increase the annual number of completed adoptions. Status #1: The number of children placed in adoptive homes increased by 31 from 2007 to 2008 and climbed again in FY09 by an additional 52 completed adoptions.	**B1: Promote the adoption of older youth ages 12 - 18 years.** Target #1: Increase the number of adoptions for youth age 12 - 18 years. Status #1: The number of adoptions of Alaska youth age 12 through 18 increased by 36% from FY07 to FY08 and another 29% in FY09.

Performance Detail

A: Result - Child abuse and neglect is prevented.

Target #1: Increase the number of Early Intervention/Infant Learning Program screenings for children age 0-3 to meet federal requirements.

Status #1: The number of children aged 0 - 3 that have been screened through the Early Intervention and Infant Learning Programs has more than tripled in the past 4 years. In FY03, 113 children were screened. In FY08, 425 children were screened. That number decreased by 11% in FY09.



Methodology: Data Source: Office of Children's Services Prevention Unit.

Number of Children Screened Annually

Fiscal Year	No. of Screenings	Target
FY 2009	380	800
FY 2008	425	800
FY 2007	408	800
FY 2006	278	800
FY 2005	225	800
FY 2004	200	800
FY 2003	113	800

Analysis of results and challenges: The Early Intervention/Infant Learning program (EI/ILP) goal is to have every child under the age of three with a substantiated protective services report screened and thus achieve federal compliance within three years. Currently EI/ILP screens only 40 percent of the required screenings under the Child Abuse Prevention and Treatment Act.

In 2003, Congress passed the Strengthening Families Bill requiring all children birth through three years of age who have been abused or neglected to be referred to the Early Intervention/Infant Learning (EI/ILP) program. By referring all 0-3 year old children who have a substantiated finding of abuse or neglect, the EI/ILP program can conduct an initial screening to identify speech and language delays, cognitive and motor delays and social and emotional delays and then connect families to any needed services. By linking families with services aimed at remedying identified needs of very young children, further abuse and neglect can be negated as associated risk factors are alleviated.

While called prevention services, abuse or neglect has already occurred, and by providing this screening and subsequent services, the likelihood of repeat maltreatment is reduced.

The program, as the number of screenings increase, is improving strategies to meet the 100% goal. This task becomes more complex as increased attention related to the behavioral health needs of very young children increases. In the past, the need for these services and a child's eligibility for these services were based on education based domains of development. Strategies must be developed to assure referrals of children who are not yet of school age.

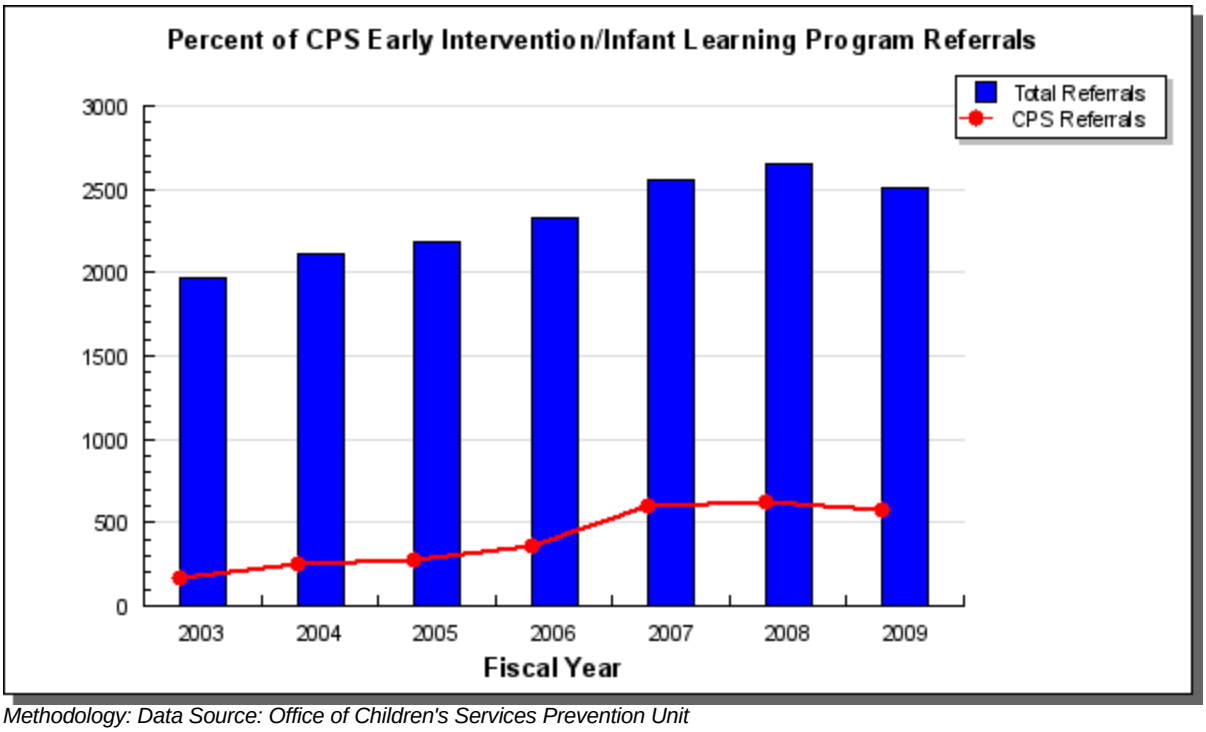
In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. Current programs do not have the capacity to provide adequate training and support to address the social and emotional needs of children currently enrolled in services, much less children with difficulties solely in social and emotional delays. Since 2003, Alaska has seen a 56% increase in the number of referrals from child protective services and expects this number to rise as child protection services and EI/ILP continue to improve communication and understanding of how best to provide supports to these children and families.

EI/ILP continues to identify an increase in children demonstrating delays in social and emotional development and continues to promote resource development in the area of identification and appropriate treatment training for staff to address the issue. EI/ILP currently has a cohort of six providers receiving training in the treatment of social and emotional delays.

A1: Strategy - Increase the number of referrals from Children's Protective Services to Early Intervention/Infant Learning Program services.

Target #1: Increase the percentage of child protection services referrals provided to children ages 0-3 and attain federal compliance.

Status #1: Child Protective Services referrals completed by the Early Intervention and Infant Learning programs have increased 55% from 2003 to 2008. Numbers fell by only 1% in FY09.



Methodology: Data Source: Office of Children's Services Prevention Unit

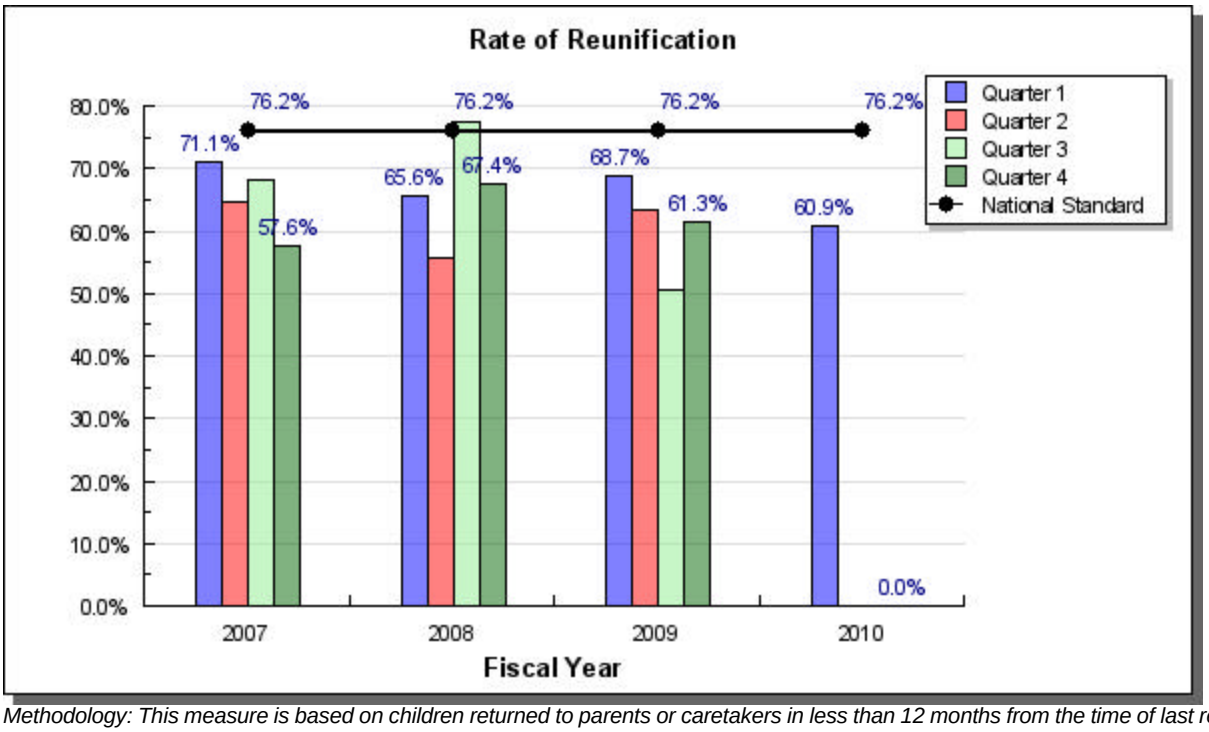
Percent of CPS Early Intervention/Infant Learning Program Referrals

Fiscal Year	Total Referrals	CPS Referrals	Percent	Target
FY 2009	2503	574	21%	5% increase
FY 2008	2657	630	22%	
FY 2007	2557	602	21%	
FY 2006	2331	363	15%	
FY 2005	2182	280	13%	
FY 2004	2107	248	12%	
FY 2003	1964	169	9%	

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) has seen a significant increase in overall referrals in the past 3 years. The slight decrease in FY 2009 is related to higher need with no increase in resources. Additional resources are available in FY 2010 and a stabilization of referrals is anticipated.

A2: Strategy - To reunify children in out-of-home placements with parents or caretakers as soon as it is safe to do so.

Target #1: Increase the rate of children reunified with their parents or caretakers within 12 months of removal.
Status #1: Annual rates of all children reunified with their parents or caretakers within 12 months of removal dropped by 5.5% in FY09. The first quarter of FY10 remains at 61%.



Methodology: This measure is based on children returned to parents or caretakers in less than 12 months from the time of last removal.

The Office of Children's Services is bringing state performance measures in line with federal measures and methodologies. Therefore, this chart contains newly calculated measures back to Quarter 1 of 2007, and will in many cases include adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

Data Source: National Standards are established by the Administration for Children and Families, Children's Bureau.

Data Source: Alaska's Online Resources for the Children of Alaska (ORCA) submission to the National Child Abuse and Neglect Data System (NCANDS).

Rate of Reunification

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National Standard
FY 2010	60.9%	0	0	0	76.2%
FY 2009	68.7%	63.4%	50.6%	61.3%	76.2%
FY 2008	65.6%	55.6%	77.4%	67.4%	76.2%
FY 2007	71.1%	64.8%	68.1%	57.6%	76.2%

Analysis of results and challenges: This measure represents the percentage of children that were returned to their parents or caretakers in less than twelve months from the time of the latest removal, known as the rate of reunification. While the Office of Children's Services (OCS) did achieve its goal as mandated by the 2002 Federal Performance Improvement Plan, we have not met national standards as set by the federal Administration for Children and Families Children's Bureau. There is much room for improvement in reunifying children with their families in a twelve month period.

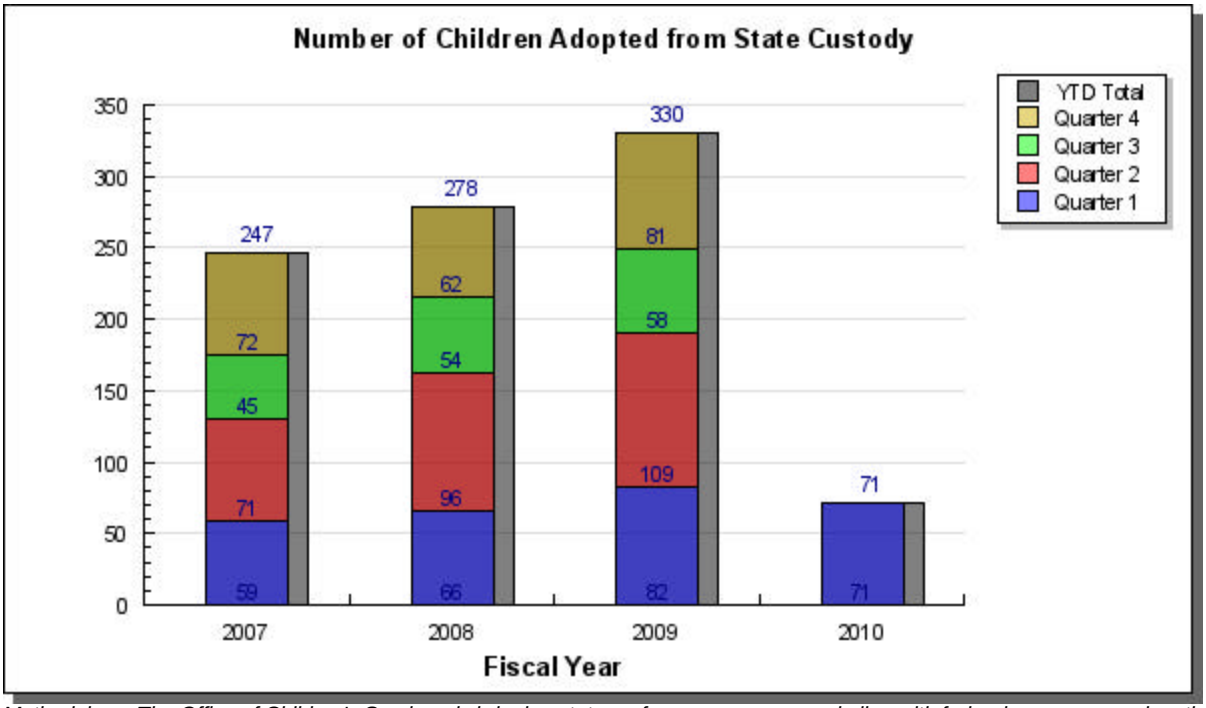
The Alaska rate of reunification dropped by 5.5% between FY 2008 and FY 2009. Efforts to improve this measure include collaboration with the Court Improvement Committee to highlight the need for Assistant Attorney Generals, Guardians ad Litem, Court Appointed Special Advocates, and judges to assist in helping the OCS to achieve permanency goals more timely.

By successfully completing the implementation of the new practice model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new model encourages workers to continue to assess through the life of the case whether children can be safely returned to their parents before all of the case plan requirements are met. If the reason OCS took children into custody was due to the child being unsafe, then the threshold for their return ought to be the same. Ongoing case plans can be monitored with children in their homes more easily with the family reunified than by requiring the family achieve success by reducing all the risk factors as well.

This model provides that the grantees use an assessment process to be completed with the family upon entry into the program and at different intervals in the life of the case, in order to assess the progress and safety factors as well as increase family functioning to ensure reunification. The grantees also provide for an in-home component to provide face-to-face contact with the family to gather assessment information and formulate a reunification plan.

B: Result - Safe and timely adoptions.

Target #1: Increase the annual number of completed adoptions.
Status #1: The number of children placed in adoptive homes increased by 31 from 2007 to 2008 and climbed again in FY09 by an additional 52 completed adoptions.



Methodology: The Office of Children's Services is bringing state performance measures in line with federal measures and methodologies. Therefore, this chart contains newly calculated measures and in many cases include adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

Data Source: Online Resources for the Children of Alaska (ORCA).

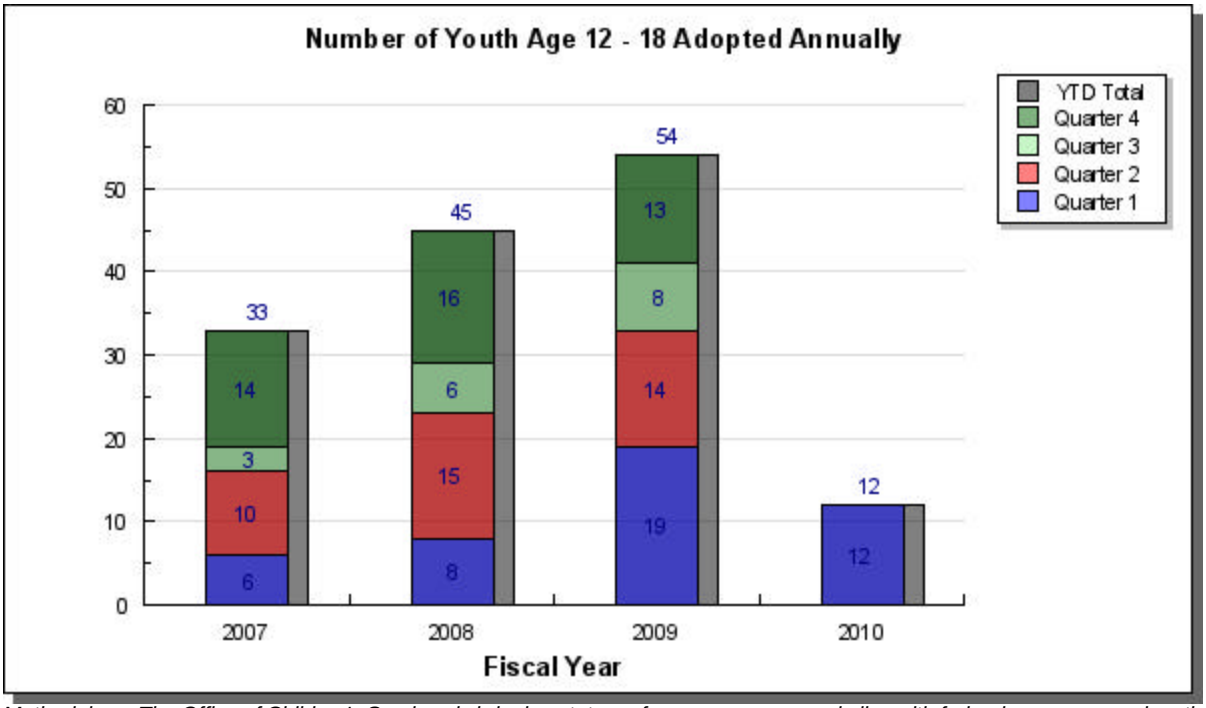
Number of Children Adopted from State Custody

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	71	0	0	0	71
FY 2009	82	109	58	81	330
FY 2008	66	96	54	62	278
FY 2007	59	71	45	72	247

Analysis of results and challenges: Since the passage of the Adoption and Safe Families Act of 1997, Alaska has seen an increase in the number of finalized adoptions for children from the Office of Children's Services (OCS) custody. As of June 30, 2008, there were 2,395 children in the subsidized adoption program. The number of children who are able to achieve permanency through adoption in the OCS system increased by 19% from FY 2008 to FY 2009. The chart above shows the number of finalized adoptions as reported by State Fiscal Year. As anticipated the adoptions of children in the OCS custody continues to increase as OCS places continued emphasis on meeting the 15 out of 22 month timeframes outlined in the Adoption and Safe Families Act.

B1: Strategy - Promote the adoption of older youth ages 12 - 18 years.

Target #1: Increase the number of adoptions for youth age 12 - 18 years.
Status #1: The number of adoptions of Alaska youth age 12 through 18 increased by 36% from FY07 to FY08 and another 29% in FY09.



Methodology: The Office of Children's Services is bringing state performance measures in line with federal measures and methodologies. Therefore, this chart contains newly calculated measures. In many cases, newly entered date will include adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

Count of children aged 12 through 18 years adopted within a state fiscal year by quarter. Data Source: Online Resources for Alaska's Children (ORCA) data system.

Number of Youth Age 12 - 18 Adopted Annually

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	12	0	0	0	12
FY 2009	19	14	8	13	54
FY 2008	8	15	6	16	45
FY 2007	6	10	3	14	33

Analysis of results and challenges: In 2006, the national focus for adoption was on the adoption of older youth from the child protection system. In Alaska, the focus on the increase of older youth adoptions (children age 12 - 18 years) has been a specific effort. National research studies have indicated that children who leave the foster care system without connections to significant adults (parents, mentors, adoptive parents, guardians) have far greater life challenges. For this reason, the Office of Children's Services has placed emphasis on assisting older youth with developing and maintaining permanent connections in their lives, and for many of these youth, the connections will need to be legally permanent.

Departmental Support Services Results Delivery Unit

Mission

Provide quality administrative services in support of the department's mission.

Core Services

- Provide divisions with necessary information to improve compliance with federal and state laws/policies to ensure our fiduciary responsibilities are met.
- Improve DHSS staff knowledge and skills and maintain high morale to continually improve performance and services for Alaskans.
- Promote cost containment. Maximize revenue.
- Provide efficient centralized administrative support to nine DHSS divisions across offices in Juneau and Anchorage.

End Result	Strategies to Achieve End Result
A: Effective and efficient delivery of administrative services facilitate the department's mission. Target #1: The Department of Health and Social Services (DHSS) administration as a percentage of department overhead should be below 2%. Status #1: DHSS administration overhead costs have met the goal of being under 2% in each of the last four years (FY05 - FY09). Target #2: Process capital grant payments within five days. Status #2: In FY09, the stability of the Facilities Section staff, coupled with the internal changes initiated in FY07 and FY08, contributed to the Section continuing to process reimbursement requests in less than five days.	
End Result	**Strategies to Achieve End Result**
B: Management of department budget processes is improved. Target #1: Improve legislative understanding of the DHSS budget. Status #1: Due to receiving 87 inquiries response times to legislative requests have not met the 80% goal of responding to legislative inquiries within five working days.	
End Result	**Strategies to Achieve End Result**
C: Effective and efficient delivery of services facilitate the department's day-to-day operations. Target #1: Reduce the length of time and number of days to respond and close out service calls.	

Status #1: During FY09, IT successfully made great strides on several department wide desktop deployment and server projects while decreasing the average number of days to complete service and incident calls. Target #2: 85% of construction projects completed on time and within budget. Status #2: Performance percentages fluctuated per quarter from a low of 40% to a high of 90% in FY09.	

Performance Detail

A: Result - Effective and efficient delivery of administrative services facilitate the department's mission.

Target #1: The Department of Health and Social Services (DHSS) administration as a percentage of department overhead should be below 2%.
Status #1: DHSS administration overhead costs have met the goal of being under 2% in each of the last four years (FY05 - FY09).

Percentage administration personal services is to total department FY budget

Year	YTD Total
2009	1.5%
2008	1.6%
2007	1.6%
2006	1.4%
2005	1.3%

Analysis of results and challenges: It is the goal of the Department of Health and Social Services (DHSS) to keep administrative costs low.

Department administration personnel services equal all of Department Support Services RDU. This number is compared to the total DHSS expenditures. This is done once a year after the year is completed.

Target #2: Process capital grant payments within five days.
Status #2: In FY09, the stability of the Facilities Section staff, coupled with the internal changes initiated in FY07 and FY08, contributed to the Section continuing to process reimbursement requests in less than five days.

Number of days to process a grant payment after receiving reports.

Fiscal Year	YTD Total
FY 2009	0.00 days
FY 2008	1.50 days
FY 2007	1.50 days
FY 2006	3.36 days
FY 2005	3.11 days

Analysis of results and challenges: In FY06, there were 93 capital grant payments, all processing within five days. In FY07, there were 101 capital grant payments, all processing within five days. In FY08 there were 131 capital grant payments, all processing within five days.

B: Result - Management of department budget processes is improved.

Target #1: Improve legislative understanding of the DHSS budget.
Status #1: Due to receiving 87 inquiries response times to legislative requests have not met the 80% goal of

responding to legislative inquiries within five working days.

% of Responses for Legislative Requests made within five working days

Fiscal Year	YTD Total
FY 2009	71%
FY 2008	79%
FY 2007	72%
FY 2006	80%
FY 2005	79%

Analysis of results and challenges: It is important that policy makers working on key budget issues get their information timely in order to make decisions regarding the DHSS budget.

The budget section received approximately 147 requests in CY 2003, 186 in CY 2004 and 236 in FY 2005.

In previous years (2002 to 2004) the data was reported by calendar year, but starting in (2005) the data is collected by fiscal year. The average processing time for the 179 requests in FY 2006 was 3.52 days. 80% were completed within five working days.

In FY 2007, the number of requests increased to 191, and there were a number of complex requests that required a week or more to complete, resulting in an overall increase to the average number of days to respond. With the increased processing time and increased number of requests, the budget section still averaged a 4.16-day turnaround in responding to legislative budget requests even though the percentage of those responded to within five working days went down.

In FY08 requests dropped to 148, largely due to the reduced session time of 90 days. The average processing time also dropped to 3.9 working days with 118 of the requests receiving responses in less than 5 days.

C: Result - Effective and efficient delivery of services facilitate the department's day-to-day operations.

Target #1: Reduce the length of time and number of days to respond and close out service calls.
Status #1: During FY09, IT successfully made great strides on several department wide desktop deployment and server projects while decreasing the average number of days to complete service and incident calls.

Average Number of Days to Complete Service

Fiscal Year	YTD Total
FY 2009	6.6 days
FY 2008	9.9 days
FY 2007	7.1 days
FY 2006	4.9 days
FY 2005	8.2 days

Methodology: FY 2005 data represents only 3 quarters. This measure began at the start of the 2nd quarter.

Analysis of results and challenges: DHSS uses an incident and project management tool to track and measure IT service delivery to our customers. Approximately 30 service delivery categories are evaluated. Examples of categories include, but are not limited to: hardware and software deployment and upgrades, setting up accounts, application work, password and file maintenance, procurement and relocation of equipment, security, and training.

During FY09, DHSS ITS implemented new and made steady progress in a number of major department-wide projects, including server consolidation and new desktop deployments and desktop software upgrades, security software deployments, enterprise software procurement and software licensing management. IT staff managed the release of a number of new or upgraded major applications. Refinement of internal incident and project management procedures, improvements in security management, upgrades to network and desktop equipment and increased emphasis on customer training have all contributed to the reduction of time spent in problem resolution.

Target #2: 85% of construction projects completed on time and within budget.
Status #2: Performance percentages fluctuated per quarter from a low of 40% to a high of 90% in FY09.

Percent of Completed Construction Projects On Time and Within Budget.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2009	40%	69%	71%	90%	67.50%
FY 2008	70%	83%	63%	81%	74.25%
FY 2007	64%	56%	78%	80%	73.00%
FY 2006	100%	100%	56%	85%	85.25%

Analysis of results and challenges: The Department began tracking construction projects in FY06.

In FY09, the department completed 68 projects, 42 of which were completed on time and 59 within budget. Due to the continued escalation in construction costs and relatively tight contractor market, the contracting environment continued to be challenging in FY09.

Health Care Services Results Delivery Unit

Mission

Manage health care coverage for Alaskans in need.

Core Services

- Provide access to appropriate health care services.
- Assure access to a full range of health care service information to our customers.

End Result	Strategies to Achieve End Result
A: Health care service reductions are mitigated by replacing general funds with alternate funds. Target #1: Reduce by 1% the GF expenses and replace them with alternate funds. Status #1: Due to an increase in both Indian Health Services (IHS) billings and adjustments to facility encounter rates the goal of increasing IHS billings was realized, with an increase of approximately 9% from FY08 to FY09.	**A1: Increase Indian Health Services (IHS) participation by 5% in expenditures.** Target #1: Increase Indian Health Services (IHS) Medicaid participation by 5% in expenditures. Status #1: Indian Health Services (IHS) Medicaid participation increased by 9% in expenditures from FY08 to FY09. This exceeded the 5% target increase. **A2: Expand fund recovery efforts.** Target #1: Increase funds recovered by 2%. Status #1: From FY08 to FY09 the Division of Health Care Services realized an increase in GF recovery of 14%, exceeding the 2% target increase.
End Result	**Strategies to Achieve End Result**
B: Affordable access to quality health care services is provided to eligible Alaskans. Target #1: Increase by 2% the number of providers enrolled in Medicaid. Status #1: While there has been mixed success in expanding the number of eligible providers, the greatest gains have been made in ancillary providers and physician extenders. Overall, enrolled providers increased from 8,917 in FY08 to 10,255 in FY09; an increase of approximately 15%.	**B1: Improve time for claim payment.** Target #1: Decrease average response time from receiving a claim to paying a claim. Status #1: The division has witnessed an increase of approximately 4 days in the average time from claim submission to claim payment, increasing from 11 days in FY08 to 15 days in FY09. This represents an increase of 36% in claims processing time. **B2: Improve payment efficiency.** Target #1: Increase the percentage of adjudicated claims paid with no provider errors. Status #1: The percentage of claims paid without error decreased from 81% during FY08 to 79% in FY09.

Performance Detail

A: Result - Health care service reductions are mitigated by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses and replace them with alternate funds.
Status #1: Due to an increase in both Indian Health Services (IHS) billings and adjustments to facility encounter rates the goal of increasing IHS billings was realized, with an increase of approximately 9% from FY08 to FY09.

Health Care Services Actuals - Other Funds (in millions)

Fiscal Year	% Federal	% General	% Other
FY 2009	58.8%	34.7%	6.5%
FY 2008	64.6%	32.3%	3.1%
FY 2007	64.8%	31.0%	4.2%
FY 2006	65.3%	28.1%	6.6%
FY 2005	71.5%	17.5%	11.0%
FY 2004	71.1%	16.6%	12.4%
FY 2003	67.5%	25.5%	7.1%
FY 2002	66.6%	27.8%	6.1%
FY 2001	66.4%	22.7%	10.9%
FY 2000	65.3%	25.5%	9.2%
FY 1999	66.0%	34.7%	.8%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, Indian Health Service, Breast and Cervical Cancer, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in the Alaska Budget System (ABS) as percentages.

As a joint federal-state program, the federal and state governments share the cost of Medicaid. Federal financial participation rates are set at the federal level, and largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called Federal Medical Assistance Percentage (FMAP).

A1: Strategy - Increase Indian Health Services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian Health Services (IHS) Medicaid participation by 5% in expenditures.
Status #1: Indian Health Services (IHS) Medicaid participation increased by 9% in expenditures from FY08 to FY09. This exceeded the 5% target increase.

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2009	$573.4	159.3	28%	9%
FY 2008	$517.9	$146.3	28%	9%
FY 2007	$490.2	$134.2	27%	-14%
FY 2006	$528.9	$155.6	29%	-12%
FY 2005	$558.2	$177.8	32%	15%
FY 2004	$503.6	$154.5	31%	15%
FY 2003	$466.6	$134.9	29%	51%
FY 2002	$385.9	$89.3	23%	22%
FY 2001	$323.0	$73.3	23%	48%
FY 2000	$268.4	$49.4	18%	32%
FY 1999	$228.6	$37.5	16%	98%

Methodology: Total expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

The % increase is the percent change in IHS expenditures from the prior year.

DHSS, FMS, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: Indian Health Service (IHS) expenditures increased from FY08 to FY09 by $13 million. The increase can be attributed to increased IHS claim filing, increased use of IHS facilities, and adjustments in encounter rates following facility rate reviews.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation, whereas non-IHS facility patient costs require a state match of GF funds on expenditures.

Background:

Increased IHS billing capacity by tribal entities assists with revenue generation. This directly contributes to tribal entities being able to maintain and hire staff to serve recipients closer to home on a more consistent basis. It also decreases the number of American Indian/Alaska Native (AI/AN) beneficiaries going to non-tribal facilities. Certain tribal entities with 638 status receive 100% FMAP for service delivery to AI/AN beneficiaries, thus assisting the state with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that AI/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an AI/AN beneficiary is connected to a tribal healthcare delivery system that is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door beneficiaries enter, for example, whether it's behavioral health, clinic, or dental, they become a part of the larger tribal healthcare delivery system of that region. The more revenue they generate per service category, the more consistent the long-term system becomes.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Status #1: From FY08 to FY09 the Division of Health Care Services realized an increase in GF recovery of 14%, exceeding the 2% target increase.

Medicaid Recoveries: Drug Rebates & Third Party Liability (TPL) Collections (in millions)

Year	Drug Rebates	TPL	Total	% Change
2009	24.0	10.2	34.2	14%
2008	21.6	8.4	30.0	0%
2007	15.5	14.5	30.0	19%
2006	27.5	9.4	36.9	5%
2005	30.2	8.7	38.9	32%
2004	19.4	10.1	29.5	18%
2003	17.0	8.0	25.0	N/A

Analysis of results and challenges: Overall TPL collections for Health Care Services increased approximately 14% between FY08 and FY09. However, there was no overall increase in collections during FY08. The increase in recoveries experienced during FY09 can be attributed to a number of contributing factors, among them increased receipts recovered by the TPL contractor, increased subrogation recoveries, and more stringent application of Medicare eligibility.

B: Result - Affordable access to quality health care services is provided to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled in Medicaid.
Status #1: While there has been mixed success in expanding the number of eligible providers, the greatest gains have been made in ancillary providers and physician extenders. Overall, enrolled providers increased from 8,917 in FY08 to 10,255 in FY09; an increase of approximately 15%.

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2009	2,470 -0.36%	128 +19.63%	2,448 +24.77%	992 -47.12%	10,255 +15.01%
2008	2,479 -0.24%	107 -61.09%	1962 -2.87%	1,876 +22.14%	8,917 -25.16%
2007	2,485 +1.22%	275 -30.73%	2,020 -2.93%	1,536 -28.49%	11,915 -4.64%
2006	2,455	397	2,081	2,148	12,495

Analysis of results and challenges: Provider enrollment is difficult to compare from any one period to another for a variety of reasons:

1. Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons. A participating provider may enroll without rendering services, and a provider may be enrolled and stop billing for services without discontinuing their enrollment.

2. The time limit for submission of claims is one year from the date services were rendered, and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year.

3. Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters.

4. There are, at present, no strategies to increase provider enrollment or participation.

Timely payment is part of the strategy for retaining providers who participate in Medicaid. Provider retention is necessary if the department is to meet its goal of affordable access to health care. While it probably does not contribute to increased provider participation, failure to pay timely could negatively impact access to care if dissatisfied providers stop seeing Medicaid patients.

B1: Strategy - Improve time for claim payment.

Target #1: Decrease average response time from receiving a claim to paying a claim.
Status #1: The division has witnessed an increase of approximately 4 days in the average time from claim submission to claim payment, increasing from 11 days in FY08 to 15 days in FY09. This represents an increase of 36% in claims processing time.

Operations Performance Summary-Annual Average Days/Entry Date to Claims Paid Date

Fiscal Year	Medicaid Claims	Avg Days	Days Changed
FY 2009	7,509,326	15	4
FY 2008	7,263,956	11	-7
FY 2007	7,293,304	18	6
FY 2006	7,721,709	12	-1
FY 2005	7,903,523	13	3
FY 2004	6,690,344	10	0
FY 2003	5,615,072	10	-2
FY 2002	4,959,864	12	0
FY 2001	4,409,121	12	2
FY 2000	3,720,254	10	0

Methodology: Source: MARS MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between FY08 and FY09 increased from 11 days to 15 days.

There may be more than one reason for the increase in time from submission to payment, although the most prominent of these would be the changeover of claims processing contractors from First Health Services to Affiliated Computer Services. As with any change in business practices and personnel, there will be a needed period of adjustment before medical claims processing efficiencies are realized from the completion of employee training and familiarization of employees with practices and procedures.

All of the above would have had impact on processing time.

B2: Strategy - Improve payment efficiency.

Target #1: Increase the percentage of adjudicated claims paid with no provider errors.
Status #1: The percentage of claims paid without error decreased from 81% during FY08 to 79% in FY09.

Error Distribution Analysis-Change in the percentage of adjudicated claims paid with no provider errors

Year	Medicaid Claims Paid	% No Errors	% Change
2009	5,858,223	79%	-2%
2008	5,550,357	81%	9%
2007	5,606,347	72%	-2%
2006	6,082,318	74%	2%
2005	6,150,027	72%	-4%
2004	5,106,692	76%	3%
2003	4,776,730	73%	-1%
2002	4,202,677	74%	1%
2001	3,670,331	73%	1%
2000	3,076,978	72%	0%

Methodology: Chart Notes
1. This measurer is updated quarterly.
2. Source: MARS MR-0-11-T.

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. Affiliated Computer Services, Medicaid's fiscal agent,

provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first quarter of FY06 and FY07 in Pharmacy. During FY06, the Department of Health and Social Services (DHSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, DHSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice. Therefore, the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required DHSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

Juvenile Justice Results Delivery Unit

Mission

Hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

Core Services

- Short-term secure detention
- Court-ordered institutional treatment for juvenile offenders
- Intake investigation management of informal or formal response
- Probation supervision and monitoring
- Juvenile offender skill development

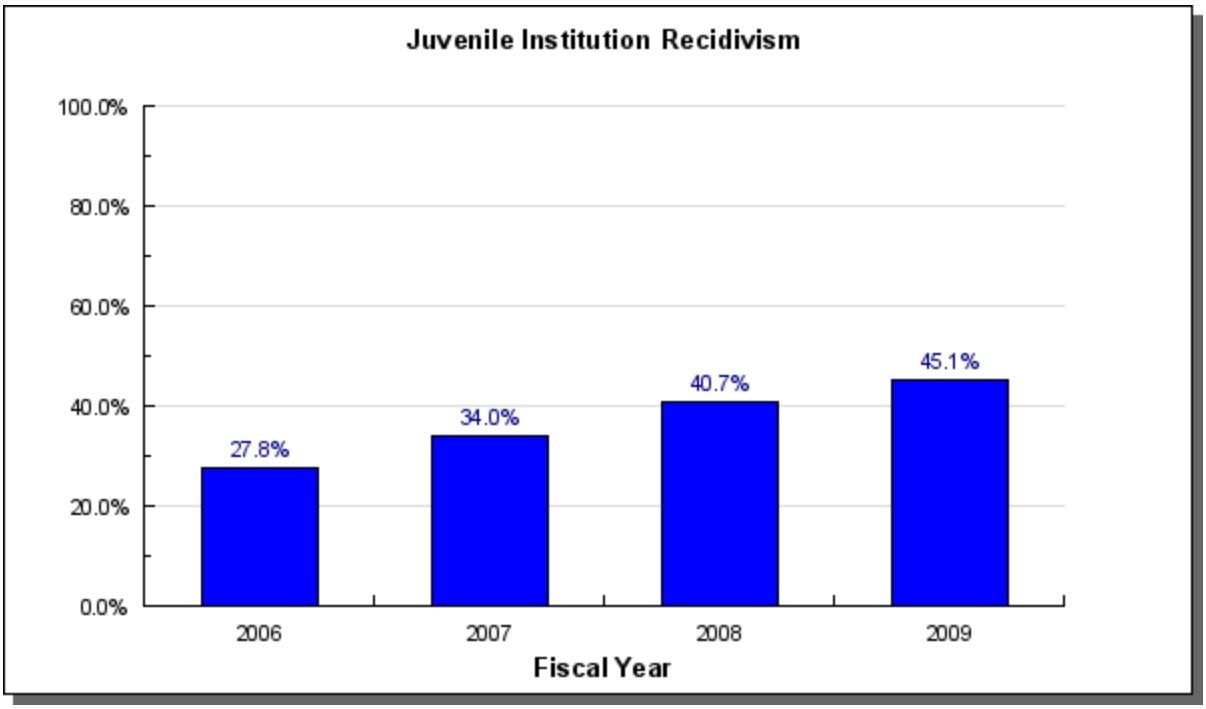
End Result	Strategies to Achieve End Result
A: The ability to hold juvenile offenders accountable for their behavior is improved. Target #1: Reduce percentage of juveniles who reoffend following release from institutional treatment facilities to less than 33%. Status #1: The defined recidivism rate for juveniles released from secure treatment in FY07 and followed up in FY09 was 45.1%. Target #2: Reduce percentage of juveniles who reoffend following completion of formal court-ordered probation supervision to less than the average rate in the three prior years (27.9%). Status #2: The defined recidivism rate for the probation population was 30.28%, a percentage similar to that identified in the previous two years. Target #3: Alaska's juvenile offense rate will be reduced by 5% over a two-year period. Status #3: The number of juvenile referrals (reports of juvenile offenses from law enforcement) made to the Division of Juvenile Justice declined 13.7% between FY08 and FY09 and declined 17.7% between FY07 and FY09. Target #4: Divert at least 70% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses. Status #4: The proportion of juveniles with at least one offense (a criminal charge in a report from law enforcement alleging a juvenile perpetrator) diverted from the formal court process matched the goal of 70%. Target #5: Improve the ability to collect ordered restitution at the time of case closure to 100% of what	**A1: Improve the timeliness of response to juvenile offenses.** Target #1: Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement. Status #1: The speed with which juvenile justice staff responded to referrals (reports from law enforcement of juvenile activity) remained above the goal, with 82% of reports responded to within 30 days. The average response time for juvenile probation staff to respond to referrals was 16 days. **A2: Improve the satisfaction of victims of juvenile crime.** Target #1: To monitor and improve victims' satisfaction with juvenile justice services. Status #1: 61.01% of victims of person and property offenses committed by juveniles adjudicated on those offenses in FY09 had their contact information listed in the Juvenile Offender Management Information System. A sample of 23 of these victims contacted by phone expressed a moderate level of satisfaction with the services they'd received. **A3: Improve the division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the Division of Juvenile Justice (DJJ) field probation policy and procedure manual.** Target #1: All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured. Status #1: Juvenile probation officers in Alaska continued to exhibit a high degree of professionalism in

was requested or ordered. Status #5: The amount of restitution paid by juvenile offenders by the time their division supervision ended remained high in FY09, with $36,178.04 (93%) paid by juveniles out of $38,882.84 requested. Target #6: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered or requested. Status #6: The percentage of hours of community work service completed by juveniles in FY09 remained relatively consistent with that noted in previous years, with 17,052 hours of community work service completed (75.8%) out of the 22,502 hours ordered through a court process or juvenile probation officers in informal, non-court processes.	conducting casework, as demonstrated by an average 92.78% compliance rate in meeting overall case standards.

Performance Detail

A: Result - The ability to hold juvenile offenders accountable for their behavior is improved.

Target #1: Reduce percentage of juveniles who reoffend following release from institutional treatment facilities to less than 33%.
Status #1: The defined recidivism rate for juveniles released from secure treatment in FY07 and followed up in FY09 was 45.1%.



Juvenile Institution Recidivism

Fiscal Year	YTD Total
FY 2009	45.1%
FY 2008	40.7%
FY 2007	34%
FY 2006	27.8%

Analysis of results and challenges: This measure examines recidivism for youth who have been committed to and released from the Division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the state's more chronic and serious juvenile offenders compared with youth who receive only probation supervision. Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

The recidivism rate for juveniles released from Alaska's secure treatment institutions has increased over the past few years. (The definitions and procedures for measuring recidivism were set by the Division in 2006.) The increase may not be significant given that the percentage changes in recidivism in fact represent small numbers of youth. (In FY07, a total of 113 juveniles were released from secure treatment institutions.) Nevertheless, the gradual increase in recidivism among this population is enough cause for concern that the Division has formed a work group to closely examine the factors that contribute to recidivism and make recommendations for change. The Division is devoting particular attention to the high rate of recidivism noted among Alaska Native juveniles, and is working to improve its understanding of and practices with these youths.

Differences in the way states manage juvenile delinquency referrals make it challenging to compare Alaska's recidivism rate with that of other states. Sixteen of the 32 states that track recidivism do so on a 12-month basis. Among the eight states (including Alaska) that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems, the average recidivism rate was 33% (Source: Juvenile Offenders and Victims: 2006 National Report," National Center for Juvenile Justice, Pittsburgh, page 234). This number serves as the baseline goal from which Alaska works to improve its recidivism rate. This "national" recidivism rate of 33% is very similar to the average recidivism rate over the three prior years in Alaska. (In FY09, this average was 34%, based on institutional recidivism rates of 40.7% in FY08; 34.0% in FY07; and 27.8% in FY06).

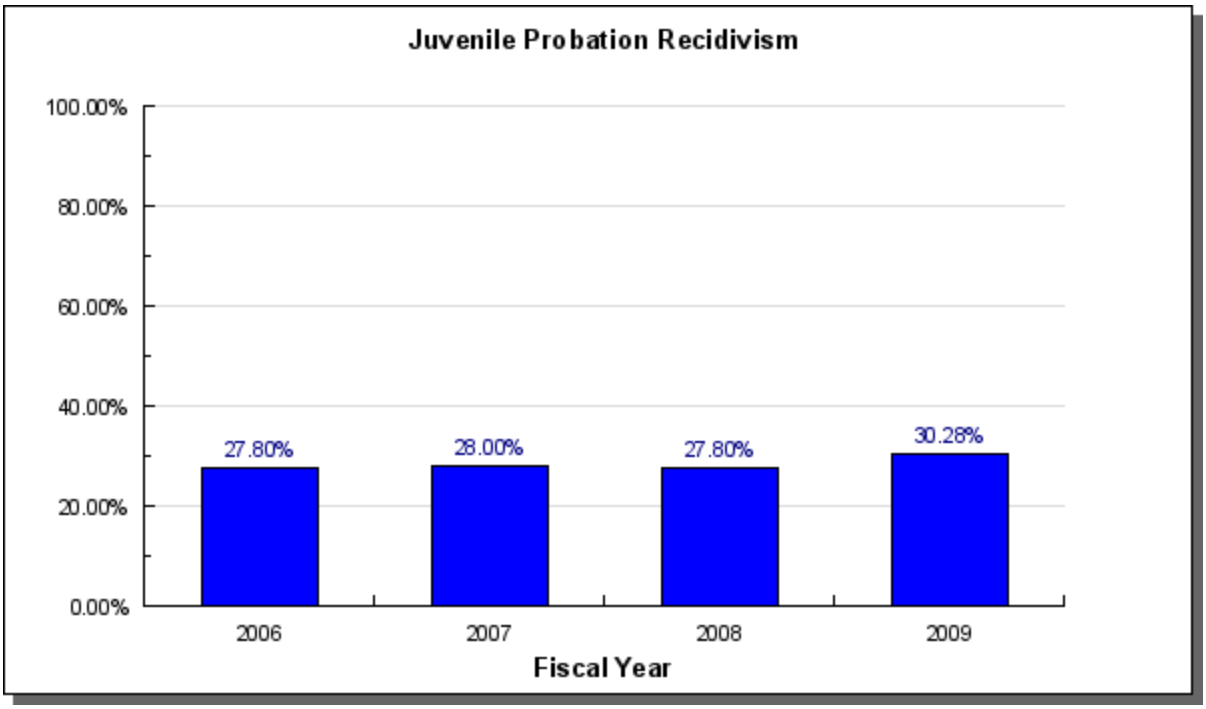
Reoffenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The Division has adopted assessment tools both for juveniles and the facilities that house them to address the root causes of their law-breaking behavior, and will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

Note: Reoffenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database and the Alaska Public Safety Information Network (APSIN). Juveniles are included in this measure if the reason for their release from the treatment facility is marked in JOMIS as "Completion of Treatment," "Court-Ordered Release," "Order Expired," "Sentence Served," "Transfer (Transitional Services Step Down)," or "Transfer to a Non-DJJ Facility." Reoffenses are defined as: any offenses that occurred within 12 months of release and that resulted in a new juvenile adjudication or adult conviction, or a probation violation resulting in a new juvenile institutionalization order. For this FY09 report, adjudication and conviction information on offenses that were committed 12 months after release by juveniles must have been entered in JOMIS or APSIN by August 1, 2009. Adjudications and convictions for motor vehicle, Fish & Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska also are excluded from analysis.

Target #2: Reduce percentage of juveniles who reoffend following completion of formal court-ordered probation supervision to less than the average rate in the three prior years (27.9%).

Status #2: The defined recidivism rate for the probation population was 30.28%, a percentage similar to that

identified in the previous two years.



Juvenile Probation Recidivism

Fiscal Year	YTD Total
FY 2009	30.28%
FY 2008	27.8%
FY 2007	28%
FY 2006	27.8%

Analysis of results and challenges: This measure examines reoffense rates for juveniles who received probation supervision while either remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized. (Recidivism rates for institutionalized youth are analyzed in a separate performance measure [above], and are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.)

The recidivism rate among the population of juveniles released from formal supervision in FY07 appears similar to the rates identified in previous years. Nevertheless, the Division is exploring the reasons that some juveniles in Alaska recidivate and will continue to work toward implementing evidence-based practices that will reduce the recidivism rate for the youth released from Division probation supervision.

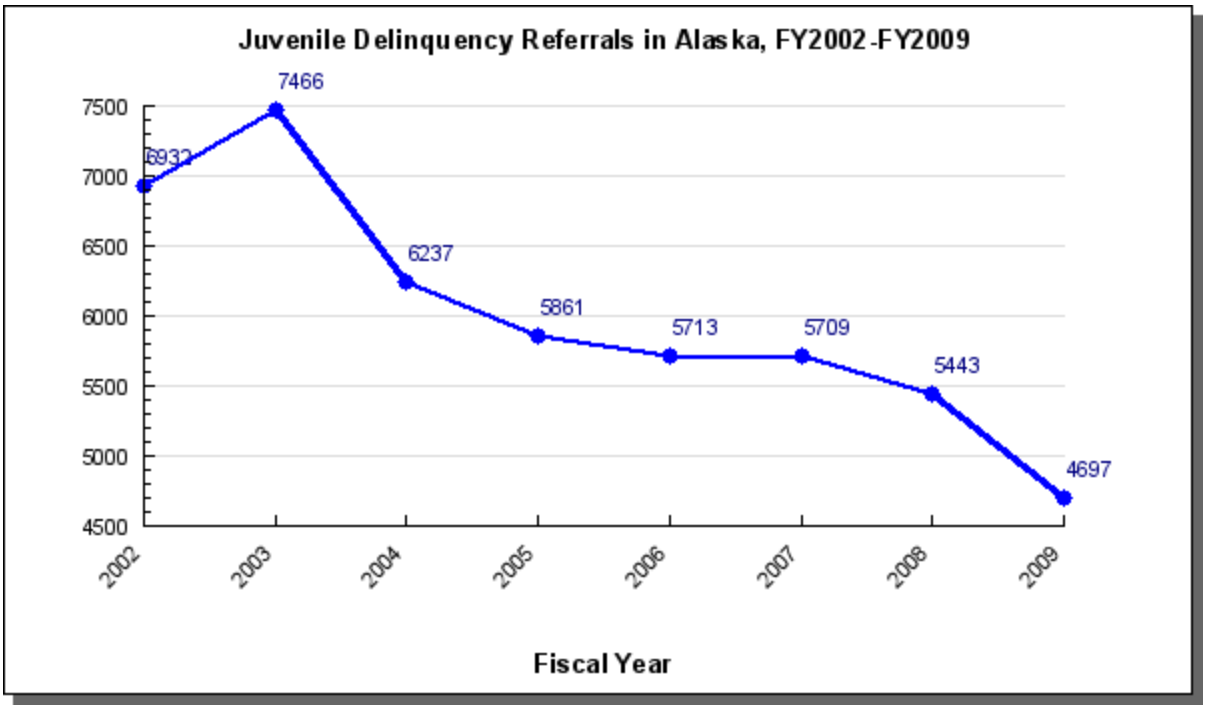
Differences in the way states manage juvenile delinquency referrals make it challenging to compare Alaska's recidivism rate with that of other states. Sixteen of the 32 states reported to track recidivism do so on a 12-month basis. Among the eight states (including Alaska) states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems, the average recidivism rate was 33%. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.) In Alaska, the three-year average recidivism rate for youth released from formal probation was 27.9% (27.8% in FY08; 28.0% in FY07; 27.8% in FY06). This number serves as the goal for this year's probation recidivism study.

Reoffenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the

context of domestic violence. The Division has received technical assistance in FY09-FY10 to assist in understanding its needs for juvenile probation needs more clearly; this information will ultimately be used to improve the Division's ability to incorporate research-based practices into probation work and ultimately improve outcomes for youth on probation supervision.

Note: Reoffenses for juveniles released from formal probation are determined by checking for entries in the Division's Juvenile Offender Management Information System (JOMIS) and the Alaska Public Safety Information Network (APSIN). This table reports the number of youth for whom court-ordered probation episodes closed during the fiscal year for one of the following reasons: "Completed Successfully," "Order Expired," "Court Termination," "Non-compliant Closed," or "Waived to Adult Status." Youth whose formal probation ends because of "Court Termination Resulting in a new Supervision," "Modified," "Revoked," "Supervision Transfer," "Declared Incompetent," or "Deceased" are not included. Recidivism for this measure is defined as re-offenses that occurred within 12 months from the time offenders were released from formal probation, and that resulted in a conviction or adjudication. (For example, the FY09 study is represented in the graph above by youth who were released from formal probation in FY07, and who re-offended within FY08. For this FY09 report, adjudication and conviction information on offenses that occurred within 12 months of release must have been entered in APSIN or JOMIS by August 1, 2009.) Youth are not included who have been reassigned to a formal probation order (with or without custody) within 7 days of release, as this typically reflects a modification of probation status or custodial placement rather than true completion of supervision. This analysis also excludes youth who were ordered to an Alaska treatment institution any time prior to their supervision end date, as these youth are included in the analysis for our institutional recidivism performance measure, above. Adjudications and convictions for Motor Vehicle, Fish & Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis.

Target #3: Alaska's juvenile offense rate will be reduced by 5% over a two-year period.
Status #3: The number of juvenile referrals (reports of juvenile offenses from law enforcement) made to the Division of Juvenile Justice declined 13.7% between FY08 and FY09 and declined 17.7% between FY07 and FY09.



Juvenile Delinquency Referrals in Alaska, FY2002-FY2009

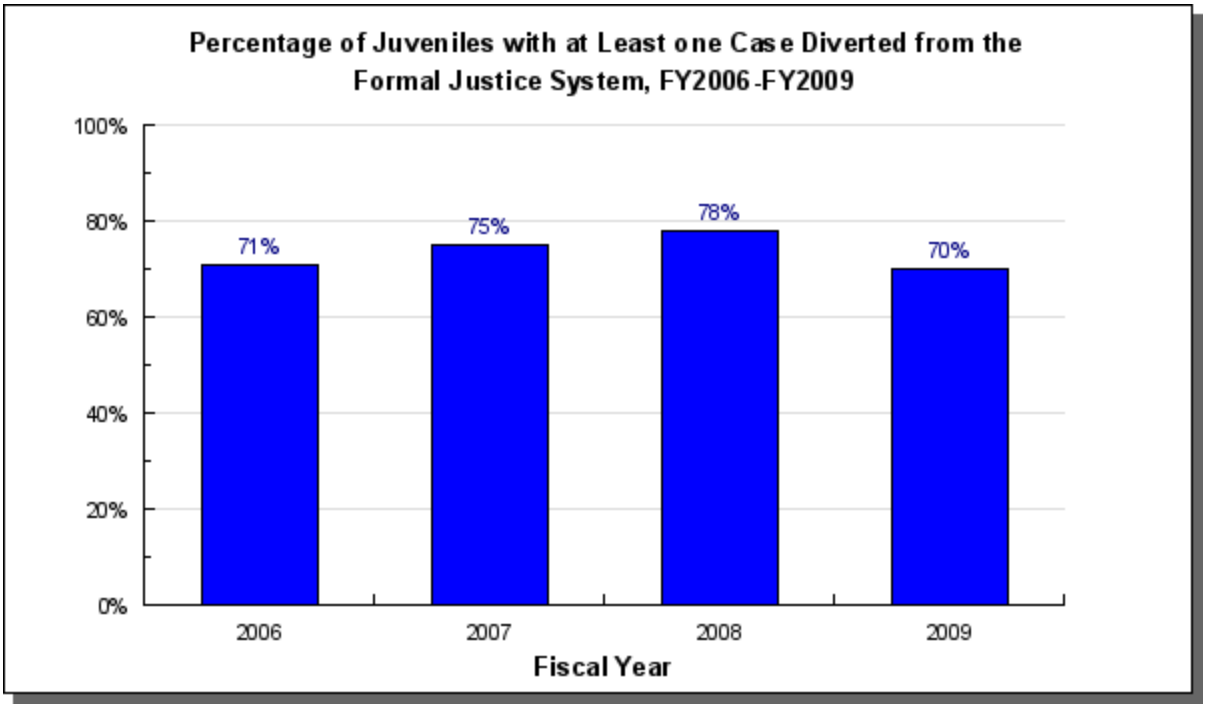
Fiscal Year	YTD Total
FY 2009	4697 -13.71%
FY 2008	5443 -4.66%
FY 2007	5709 -0.07%
FY 2006	5713 -2.53%
FY 2005	5861 -6.03%
FY 2004	6237 -16.46%
FY 2003	7466 +7.7%
FY 2002	6932

Analysis of results and challenges: Both the raw number of referrals and the percentage of these referrals per 100,000 youth population declined dramatically in FY09 compared with FY08 and FY07. The decline in referrals surpassed the target of a 5% drop in referrals over a two-year period, reflecting a continued trend of decreased juvenile delinquent activity that has been noted nationally as well as statewide over the past several years. Definitive reasons for changes in referral levels are unknown. Possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

Note: Population data for youth aged 10-17 during the years 2002-2007 is provided by the Alaska Department of Labor and Workforce Development. The population estimate for the year 2008 and 2009 was derived from the 2007 estimate and the 2010 projection from the report Alaska Population Projections 2007-2030, published by the same Department. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database by on August 21, 2009 and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 70% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.

Status #4: The proportion of juveniles with at least one offense (a criminal charge in a report from law enforcement alleging a juvenile perpetrator) diverted from the formal court process matched the goal of 70%.



Percentage of Juveniles with at Least one Case Diverted from the Formal Justice System, FY2006-FY2009

Fiscal Year	YTD Total
FY 2009	70%
FY 2008	78%
FY 2007	75%
FY 2006	71%

Analysis of results and challenges: "Diversion" refers to the process of managing juveniles cases through non-court processes, such as non-court adjustments; informal probation; referral to community panels such as youth court; or dismissals due to legal insufficiency. Diversion serves a number of important, valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and needless harm that can result from delinquency adjudication. Diversion provides opportunities for community partners and victims to take more active roles in handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to it. Diversion also is considerably less expensive and faster than the formal adversarial process. Diversion processes reduce probation caseloads as well, enabling the Division to better allocate resources and staff time to more serious offenders.

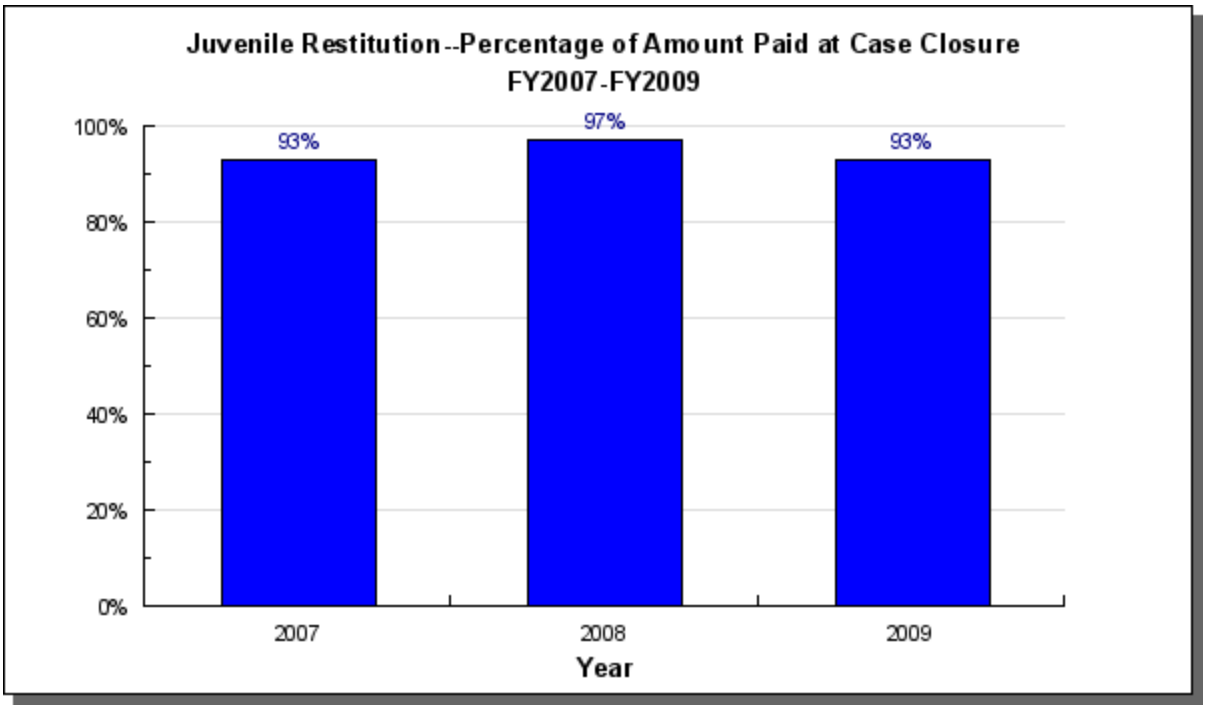
In FY09, 2,273 (70%) of 3,233 juveniles referred to the Division had at least one of their offenses managed through non-formal-court processes. This percentage was lower than the percentage identified in previous years, but this difference may not be significant. The decrease may be due as much to refinements in record-keeping and data-gathering and analysis as real change in the patterns of managing juveniles. The Division will monitor this measure in the future to determine whether the decrease in FY09 represents the beginning of a trend.

Note: For this measure, youth are considered to have been diverted away from the formal court system if the intake decision for their delinquency referrals resulted in at least one offense within the referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Referrals that are

screened and referred elsewhere, such as back to law enforcement for further information, and those that were still in process at the time this data was collected are excluded from consideration.

Target #5: Improve the ability to collect ordered restitution at the time of case closure to 100% of what was requested or ordered.

Status #5: The amount of restitution paid by juvenile offenders by the time their division supervision ended remained high in FY09, with $36,178.04 (93%) paid by juveniles out of $38,882.84 requested.



Juvenile Restitution--Percentage of Amount Paid at Case Closure FY2007-FY2009

Year	% of Amt Ordered
2009	93%
2008	97%
2007	93%
0	

Analysis of results and challenges: Restitution provides a means for juvenile offenders to make reparations to their victims and as such is a critical measure of a restorative justice agency's effectiveness. Restitution is typically requested or ordered following property loss or destruction, and provides a clear consequence of misbehavior. Through restitution, juveniles have an opportunity to demonstrate ownership and responsibility for their actions. This measure also provides a gauge of the Division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their delinquent behavior, as juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system.

Juveniles may not succeed in completing their restitution expectations for a variety of reasons; they may have aged out of the juvenile system, have had their case transferred to a formal court process, or have moved from Alaska and are difficult to locate. While the Division can exercise only limited control over some of these factors, the percentage of restitution paid has nonetheless continued to remain high, indicating that Division staff are doing a solid job of identifying appropriate amounts of restitution and working with youth to see that this expectation is met. The Division hopes to provide juvenile probation staff with an analysis of the reasons that youth have failed to complete restitution in the hope that staff can use this information to continue to improve the percentage who successfully complete all expectations of their supervision.

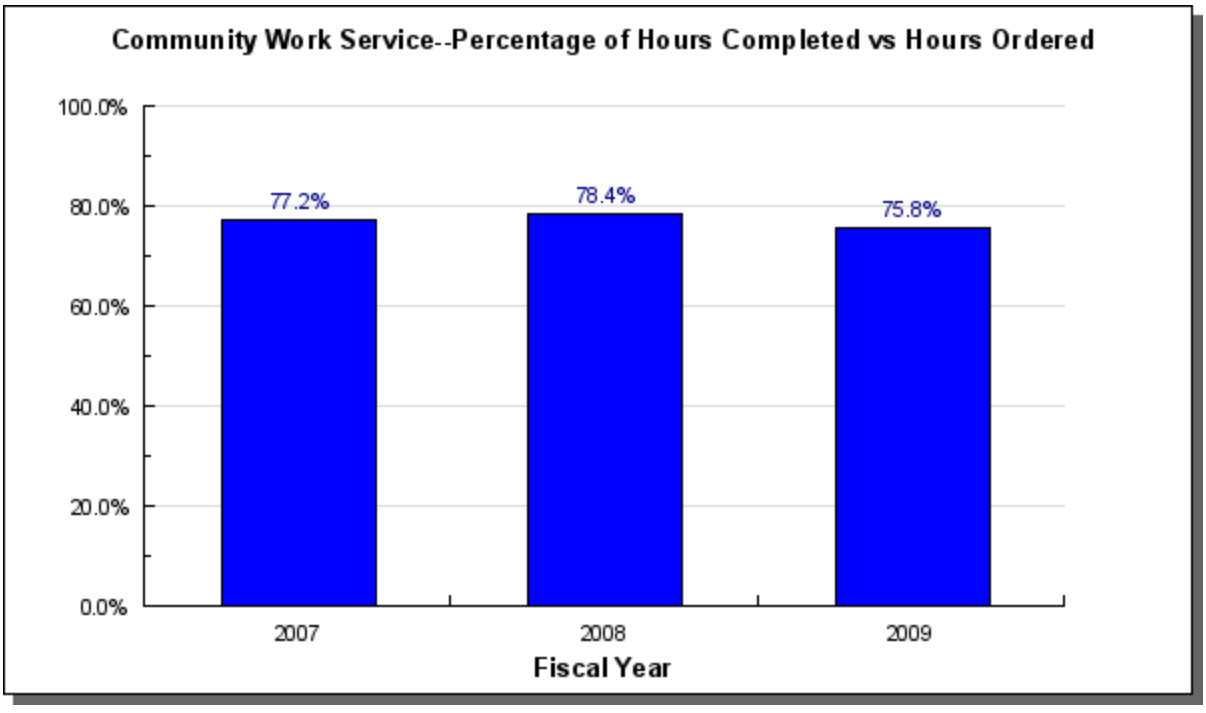
Note: Restitution requests and payments are included in this measure when they are requested by juvenile probation

officers through informal (non-court ordered) procedures, including assignments of Alaska Permanent Fund Dividends. Also included are restitution payments ordered by a court to be paid through the Division of Juvenile Justice. Not included in this measure are restitutions formally ordered through a court and monitored by the Department of Law's Collections & Support Unit. Permanent Fund Dividends garnished through formal court processes also are not included. Restitutions tracked and gathered through youth courts and other community diversion programs also are not included in this measure as these agencies track restitution as a measure of their own performance.

The amount of restitution reported as paid is that amount provided by youth whose supervision episodes that ended in FY09. The restitution must have been assigned at the same time or after the supervision episode began and closed before or at the same time that the supervision ended in the fiscal year. Data for this measure was retrieved from the Juvenile Offender Management Information System on September 8, 2009. In 2009 the Division implemented significant technical changes to its Juvenile Offender Management Information System, and recalculated the restitution figures derived in previous years as well as FY09. Reports of restitution results from previous years therefore may be slightly different from those in this report; as the new information system is refined numbers in future years also may change slightly.

Target #6: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered or requested.

Status #6: The percentage of hours of community work service completed by juveniles in FY09 remained relatively consistent with that noted in previous years, with 17,052 hours of community work service completed (75.8%) out of the 22,502 hours ordered through a court process or juvenile probation officers in informal, non-court processes.



Community Work Service--Percentage of Hours Completed vs Hours Ordered

Fiscal Year	Percentage
FY 2009	75.8%
FY 2008	78.4%
FY 2007	77.2%
FY 0	

Analysis of results and challenges: Community work service is an inherent part of a balanced and restorative justice system, providing juveniles with opportunities to: be accountable for delinquent conduct; develop a meaningful

sense of self and community; demonstrate responsibility through a tangible act of restoration and contribution. Whether offering assistance to a local nonprofit agency, a government office, or a neighbor, juveniles can gain a sense of investment in their neighborhoods and in their own abilities.

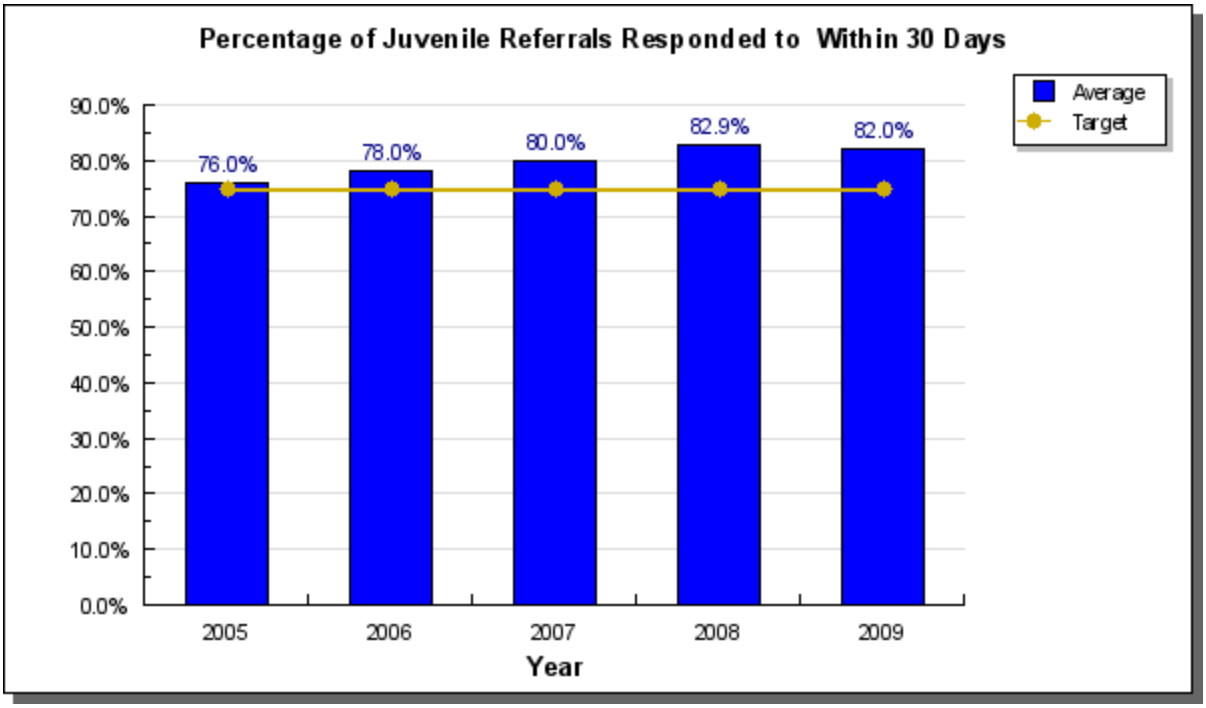
Juveniles may not succeed in completing their expectations for a variety of reasons, similar to the reasons they may not pay their restitution in full: they may have aged out of the juvenile system before their work was completed; they have had their case transferred to a formal court process, or they have moved from Alaska and are difficult to locate. Since the Division can exercise only limited control over some of the reasons youth do not complete all their community work service requirements, and community work service is typically a more challenging and involved expectation to fulfill than making restitution payments, the Division will explore in the coming year whether a goal of 100% completion of all community work service is realistic. The Division also hopes to provide juvenile probation staff with detail on the reasons that youth fail to complete community work service in the hope that staff can use this information to continue to improve the percentage who successfully complete all expectations of their supervision.

Note: Community work service ordered both through formal, court-ordered processes or informal processes directed by a juvenile probation officer are included in this measure. Community work service ordered through youth courts or other alternative justice processes are not included as these agencies typically report on community work service as a measure of their own performance. Data for this measure was retrieved from the Juvenile Offender Management Information System on September 8, 2009. The work service must have been assigned at the same time or after the supervision episode began and closed before or at the same time that the supervision ended in the fiscal year. Earlier in 2009 the Division implemented significant technical changes to its Juvenile Offender Management Information System, and recalculated the community work service figures derived in previous years as well as FY09. Reports of work service results from previous years therefore may be slightly different from those in this report. As the new information system is refined numbers in future years also may change slightly.

A1: Strategy - Improve the timeliness of response to juvenile offenses.

Target #1: Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement.

Status #1: The speed with which juvenile justice staff responded to referrals (reports from law enforcement of juvenile activity) remained above the goal, with 82% of reports responded to within 30 days. The average response time for juvenile probation staff to respond to referrals was 16 days.



Percentage of Juvenile Referrals Responded to Within 30 Days

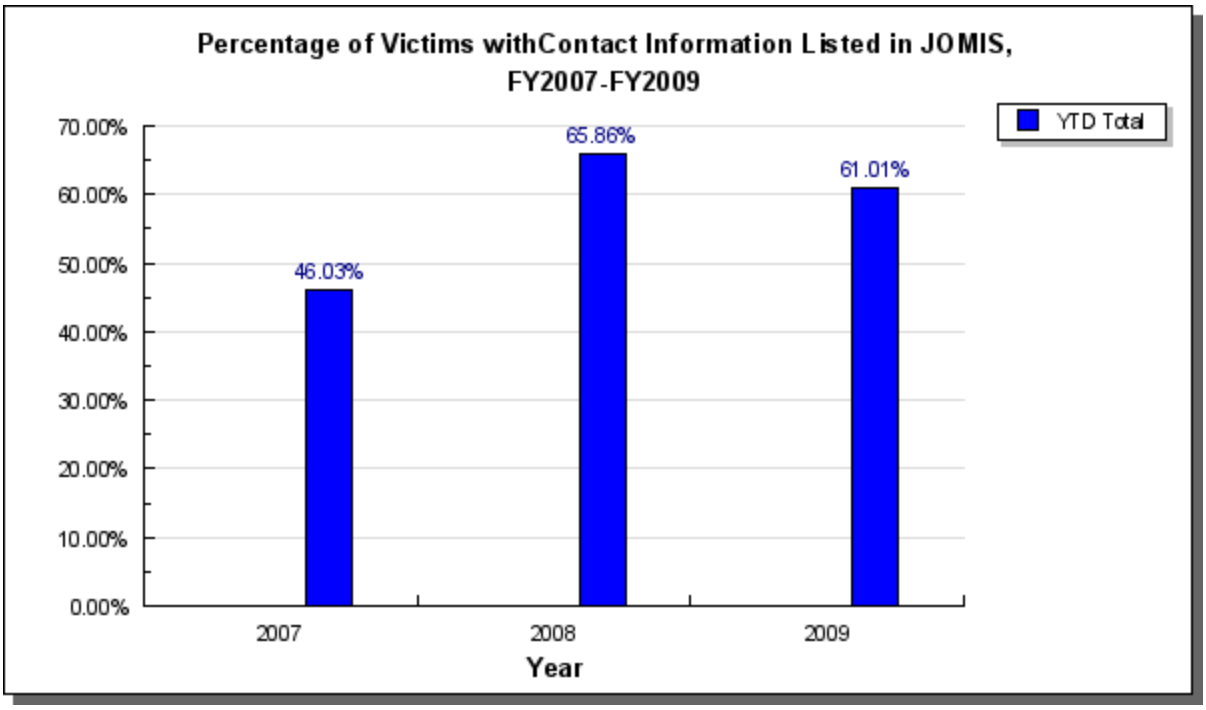
Year	Average	Target
2009	82.0	75.0
2008	82.9%	75%
2007	80%	75%
2006	78%	75%
2005	76%	75%

Analysis of results and challenges: Research indicates that responses to juvenile offenses must be timely and appropriate in order to be effective. This measure enables the Division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An "active response" is defined by the Division as one of three possible actions by staff to deal with the delinquency report (see note below). The statewide average percentage of referrals that received a response within 30 days has been consistently exceeded 75% for the last few years, suggesting that a goal of 80% may be more appropriate. The average length of time it took for juvenile probation officers to respond to referrals also continued to decline. In FY06 the average length of time required to respond to a referral was 22.4 days, while in FY09 the average was 16.02 days—a decrease of 28.5%. The reasons for this decrease are unknown but may be due to the fact that the Division's overall referral rate has decreased significantly over the past several years. Fewer referrals may enable officers to respond more quickly when reports from law enforcement are received in their offices.

Note: Delinquency reports, or "referrals" included in this analysis were those received in the fiscal year that resulted in one of the following actions: Referral Screening (review of the police report and either closing the referral or it being forwarded to a community accountability program, such as youth court), Petition Filed (resulting in an adjudication or dismissal by the court), or Intake Interview (which may result in referral being adjusted, dismissed, petitioned, or forwarded to a community accountability program).

A2: Strategy - Improve the satisfaction of victims of juvenile crime.

Target #1: To monitor and improve victims' satisfaction with juvenile justice services.
Status #1: 61.01% of victims of person and property offenses committed by juveniles adjudicated on those offenses in FY09 had their contact information listed in the Juvenile Offender Management Information System. A sample of 23 of these victims contacted by phone expressed a moderate level of satisfaction with the services they'd received.



Percentage of Victims withContact Information Listed in JOMIS, FY2007-FY2009

Year	YTD Total
2009	61.01%
2008	65.86%
2007	46.03%

Analysis of results and challenges: Alaska law and the Division's own policies and procedures recognize the importance of treating victims of juvenile delinquency with dignity, respect and fairness, and assuring victim rights is a critical aspect of the Division's restorative justice philosophy. The Division has sought for several years to determine the best way to measure its effectiveness in working with victims. In 2007 and 2008, attempts were made to determine victim satisfaction through mail-in and web-based surveys, but the number of surveys returned was so low (6-8%) that there was little the Division could conclude about the results. One factor undoubtedly contributing to the low response rates was that victim names and addresses often had not been entered accurately or completely in the Division's Juvenile Offender Management Information System (JOMIS). The first evidence of this was the large number of surveys that were returned to the Division as undeliverable. The Division later examined the electronic records of these victims and confirmed that only 46.03% (in FY07) to 65.86% (in FY08) of victims of offenses against persons or property have their names listed in JOMIS.

In July 2009, in an effort to gain some sense of the satisfaction of victims with services, the Division conducted brief telephone surveys with a sample of 23 victims of offenses that had been adjudicated in FY09. Victims from each region of the state were contacted regarding the services they'd received; on a scale from 1 (lowest satisfaction) to 5 (highest) their satisfaction averaged 3.86. This small sample size makes it difficult to conclude whether the satisfaction expressed by these victims is representative of the feelings of most victims of juvenile crime, but this result serves as a good baseline for future-year surveys.

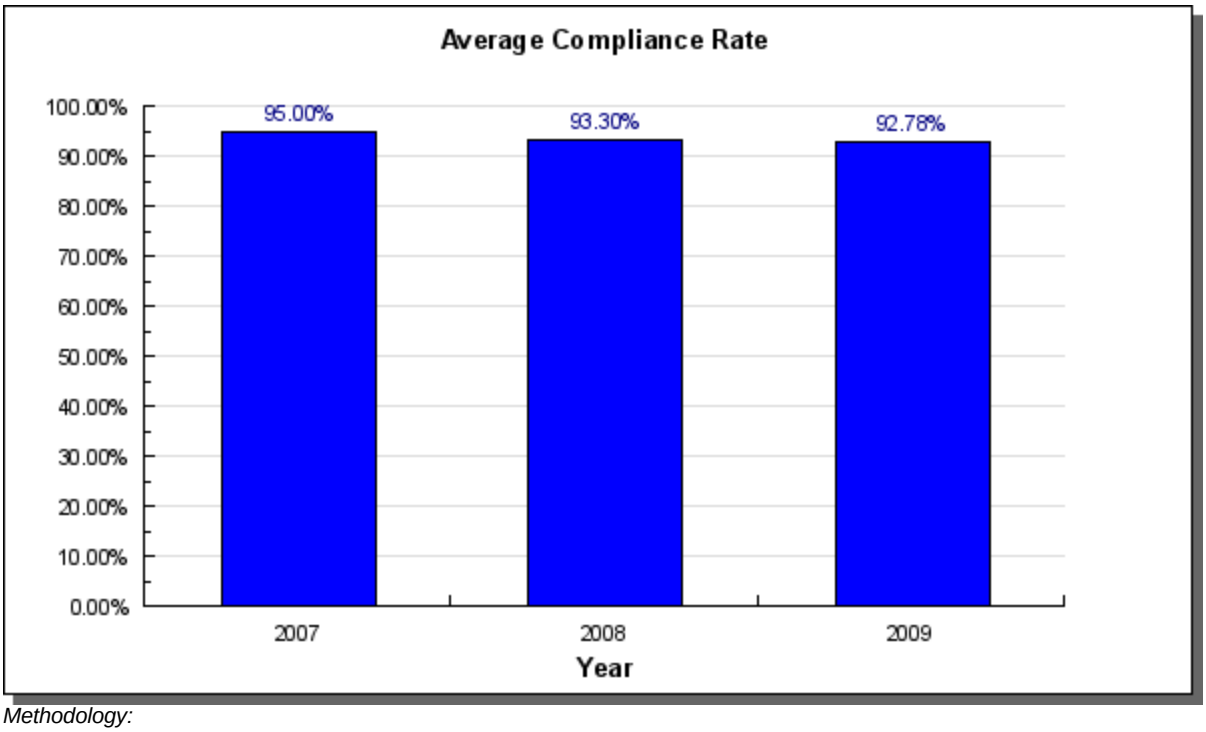
Before the Division can get an adequate picture of whether the majority of victims are satisfied with the services they receive, it must first determine whether the contact information it has for victims is complete and accurate. The Division therefore will devote attention to improving the completeness of victim contact information in the coming year.

Note: To be counted among the percentage of victims with contact information listed in the Juvenile Offender Management System (JOMIS), names of individuals and organizations who were the victims of property or person offenses, adjudicated in FY07 through FY09, had to be listed in JOMIS by August 21, 2009. Victims of non-property, non-person offenses (i.e., offenses against public order or administration, misconduct involving controlled substances or weapons, etc.) were not included in this measure because a specific victim is often difficult to identify in these cases. Victims were contacted for satisfaction surveys if the offense for which they were listed had resulted in a court-ordered adjudication and disposition for the juvenile who'd committed it in FY09. Juvenile probation supervisors contacted a randomly selected sample of 5-7 victims from their region by telephone and conducted a structured interview.

A3: Strategy - Improve the division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the Division of Juvenile Justice (DJJ) field probation policy and procedure manual.

Target #1: All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.

Status #1: Juvenile probation officers in Alaska continued to exhibit a high degree of professionalism in conducting casework, as demonstrated by an average 92.78% compliance rate in meeting overall case standards.



Methodology:

Average Compliance Rate

Year	Average
2009	92.78%
2008	93.3%
2007	95%
0	

Analysis of results and challenges: This measure monitors the Division's success in achieving compliance with casework expectations for juvenile probation officers as specified in the Division's Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload are conducted on a trimesterly basis. A representative sample of each officers' caseload is reviewed according to a standardized procedure, and the results used as a constructive means to assess an officer's performance in carrying out the required duties of the position and to ensure the delivery of appropriate services to each client. The Division continues to refine the format and procedure used to conduct audits of probation to make these audits an ever-more useful tool in determining the quality of juvenile probation officers' work.

Public Assistance Results Delivery Unit

Mission

Provide self-sufficiency and basic living expenses to Alaskans in need.

Core Services

- Temporary financial assistance and work supports for needy families with children.
- Financial and medical aid for seniors and disabled Alaskans.
- Food assistance and nutrition education for low-income households.
- Child care subsidies for needy and low-income working families.
- License child care facilities and home care providers to promote safe, quality child care.
- Access to health care by determining eligibility for Medicaid and Denali KidCare.
- Home heating assistance for low income households.
- Administrative accountability and prevention of fraud and program abuse.

End Result	Strategies to Achieve End Result
A: Low income families and individuals become economically self-sufficient. Target #1: Increase self-sufficient individuals and families by 10%. Status #1: In FY09, the Alaska Temporary Assistance Program showed a 5% decline in the number of families receiving benefits.	**A1: Increase the percentage of temporary assistance families who leave the program with earnings and do not return for six months.** Target #1: 90% of temporary assistance families leave with earnings and do not return for six months. Status #1: The FY09 percent of Alaska Temporary Assistance families who left the program with earnings and did not return for six months was 85% compared to 86% in FY08 and 81% in FY02. **A2: Increase the percentage of temporary assistance families with earnings.** Target #1: 40% of temporary assistance families with earnings. Status #1: The percent of Alaska Temporary Assistance families with earnings for FY09 decreased to 31% from the past four year norm. **A3: Increase the percentage of temporary assistance families meeting federal work participation rates.** Target #1: 50% of temporary assistance families meet federal work participation rates. Status #1: In FFY09, 37% of Alaska Temporary Assistance families met the federal participation requirements, exceeding the federal target of 33%. **A4: Improve timeliness of benefit delivery.** Target #1: 95% of food stamp expedited service applications are processed within 5 days. Status #1: In FY09, 90% of emergency food stamp applications were processed within 5 days.

	Target #2: 96% of new food stamp applications are processed within 30 days. Status #2: In FY09, 86% of food stamp initial applications were processed within 30 days with an overall average processing time of 18 days. Target #3: 99.5% of food stamp recertification applications are processed within 30 days. Status #3: In FY09, 86% of food stamp recertification applications were processed within 30 days. Target #4: 90% of temporary assistance applications are processed within 30 days. Status #4: In FY09, 65% of Alaska Temporary Assistance applications were processed within 30 days with an overall average processing time of 21 days. Target #5: 90% of Medicaid applications are processed within 30 days. Status #5: In FY09, 71% of Medicaid applications were processed within 30 days, a 7 percentage point increase from FY08. **A5: Improve accuracy of benefit delivery.** Target #1: 93% of food stamp benefits are accurate. Status #1: In FFY08, 92.6% of food stamp benefits were accurate. Target #2: 95% of temporary assistance benefits are accurate. Status #2: The FFY07 Alaska Temporary Assistance benefit accuracy is 99%, a 5-year high. Target #3: 93% of Medicaid eligibility determinations are accurate. Status #3: In FFY09, 99% of the Medicaid eligibility determinations were accurate. **A6: Increase the percentage of subsidy children in licensed care.** Target #1: 76% of subsidy children are in licensed care. Status #1: In FY09, 71% of children receiving child care assistance were in licensed care, down from 78% in FY06.

Performance Detail

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Status #1: In FY09, the Alaska Temporary Assistance Program showed a 5% decline in the number of families receiving benefits.

Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2010	10%	0	0	0	10%
FY 2009	-10%	-6%	-2%	-5%	-5%
FY 2008	-7%	-7%	-5%	-6%	-6%
FY 2007	-5%	-11%	-13%	-10%	-9%
FY 2006	-23%	-22%	-19%	-20%	-22%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2002	-16%	6%	4%	3%	-2%

Analysis of results and challenges: Overall, there has been a 61% decline in the caseload since FY96.

The goal is for clients to move off Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, families with more significant challenges to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

A1: Strategy - Increase the percentage of temporary assistance families who leave the program with earnings and do not return for six months.

Target #1: 90% of temporary assistance families leave with earnings and do not return for six months.
Status #1: The FY09 percent of Alaska Temporary Assistance families who left the program with earnings and did not return for six months was 85% compared to 86% in FY08 and 81% in FY02.

Percent of Temporary Assistance Families Who Leave the Program With Earnings and Do Not Return for 6 Months

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2010	82%	0	0	0	82%
2009	88%	86%	83%	82%	85%
2008	86%	86%	87%	84%	86%
2007	88%	88%	86%	85%	87%
2006	87%	87%	80%	84%	85%
2005	88%	85%	80%	82%	84%
2004	90%	85%	79%	80%	84%
2003	85%	87%	82%	82%	84%
2002	83%	83%	76%	81%	81%

Analysis of results and challenges: The goal is for clients to move off Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. The measurement ties in job retention, since retaining employment is directly related to remaining off Temporary Assistance.

The division provides childcare and supportive services to support employed families during the transition to self-sufficiency. Supportive services include case management support to continue coaching the employed client during this vulnerable period.

To calculate this measure, we divide the number of cases that closed with earnings six months ago who are not in the current caseload by the number of cases that closed with earnings six months ago. The calculation for the quarterly figures is a weighted average of the three months in the quarter. The YTD total is a weighted average of all the months so far in the year.

A2: Strategy - Increase the percentage of temporary assistance families with earnings.

Target #1: 40% of temporary assistance families with earnings.
Status #1: The percent of Alaska Temporary Assistance families with earnings for FY09 decreased to 31% from the past four year norm.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2010	31%	0	0	0	31%
2009	34%	31%	28%	31%	31%
2008	35%	33%	32%	35%	33%
2007	36%	32%	32%	36%	34%
2006	34%	32%	32%	36%	34%
2005	34%	31%	30%	35%	33%
2004	31%	29%	29%	35%	31%
2003	30%	28%	27%	32%	29%
2002	31%	28%	27%	31%	29%

Analysis of results and challenges: This is a measure of current Temporary Assistance recipients who have earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare to work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient.

The calculation for the quarterly figures is a weighted average of the three months in the quarter. The YTD total is a weighted average of all the months so far in the year.

A3: Strategy - Increase the percentage of temporary assistance families meeting federal work participation rates.

Target #1: 50% of temporary assistance families meet federal work participation rates.
Status #1: In FFY09, 37% of Alaska Temporary Assistance families met the federal participation requirements, exceeding the federal target of 33%.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2009	38%	36%	36%	36%	37%
2008	44%	42%	41%	45%	42%
2007	47%	46%	46%	50%	47%
2006	42%	43%	44%	44%	44%
2005	39%	37%	39%	40%	40%
2004	36%	36%	36%	37%	37%
2003	32%	33%	33%	34%	34%
2002	38%	37%	36%	36%	36%

Analysis of results and challenges: Temporary Assistance (TA) is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

The quarterly figures are YTD figures. The federal participation rate calculation is a running YTD figure.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

A4: Strategy - Improve timeliness of benefit delivery.

Target #1: 95% of food stamp expedited service applications are processed within 5 days.
Status #1: In FY09, 90% of emergency food stamp applications were processed within 5 days.

Percentage of food stamp expedited service households that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	88.5%	0	0	0	88.5%
FY 2009	89.6%	90.2%	87.2%	89.6%	89.6%
FY 2008	93.1%	90.4%	86.6%	88.4%	88.4%
FY 2007	96.5%	96.2%	96.3%	96.4%	96.4%
FY 2006	95.0%	95.6%	96.0%	95.7%	95.7%
FY 2005	90.9%	92.3%	92.7%	93.5%	93.5%
FY 2004	93.2%	93.8%	94.5%	94.7%	94.7%
FY 2003	94.0%	90.5%	90.8%	92.1%	92.1%
FY 2002	95.4%	94.5%	93.4%	93.4%	93.4%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The quarterly data are YTD figures.

Target #2: 96% of new food stamp applications are processed within 30 days.
Status #2: In FY09, 86% of food stamp initial applications were processed within 30 days with an overall average processing time of 18 days.

Percentage of new food stamp applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	86.0%	0	0	0	86.0%
FY 2009	88.9%	89.2%	86.9%	85.8%	85.8%
FY 2008	94.8%	92.2%	89.6%	90.3%	90.3%
FY 2007	97.2%	97.3%	97.2%	97.1%	97.1%
FY 2006	95.4%	95.9%	96.1%	96.2%	96.2%
FY 2005	95.2%	95.5%	95.7%	95.9%	95.9%
FY 2004	96.2%	96.1%	96.3%	96.5%	96.5%
FY 2003	95.9%	95.1%	95.1%	95.5%	95.5%
FY 2002	93.0%	94.2%	94.3%	94.7%	94.7%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #3: 99.5% of food stamp recertification applications are processed within 30 days.
Status #3: In FY09, 86% of food stamp recertification applications were processed within 30 days.

Percentage of food stamp recertification applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	84.8%	0	0	0	84.8%
FY 2009	89.9%	89.0%	84.3%	85.8%	85.8%
FY 2008	94.6%	93.9%	92.6%	92.4%	92.4%
FY 2007	99.7%	99.5%	99.5%	99.1%	99.1%
FY 2006	99.4%	99.5%	99.5%	99.5%	99.5%
FY 2005	99.5%	99.5%	99.5%	99.6%	99.6%
FY 2004	99.6%	99.6%	99.6%	99.6%	99.6%
FY 2003	99.5%	99.5%	99.4%	99.4%	99.4%
FY 2002	99.8%	99.8%	99.7%	99.6%	99.6%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #4: 90% of temporary assistance applications are processed within 30 days.
Status #4: In FY09, 65% of Alaska Temporary Assistance applications were processed within 30 days with an overall average processing time of 21 days.

Percentage of Temporary Assistance applications that meet time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	67%	0	0	0	67%
FY 2009	78%	80%	74%	65%	65%
FY 2008	83%	82%	81%	81%	81%
FY 2007	85%	83%	83%	84%	84%
FY 2006	88%	86%	86%	87%	87%
FY 2005	85%	84%	85%	85%	85%
FY 2004	88%	88%	88%	88%	88%
FY 2003	90%	88%	89%	90%	90%
FY 2002	83%	86%	85%	86%	86%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #5: 90% of Medicaid applications are processed within 30 days.
Status #5: In FY09, 71% of Medicaid applications were processed within 30 days, a 7 percentage point increase from FY08.

Percentage of Medicaid applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	74%	0	0	0	74%
FY 2009	77%	72%	71%	71%	71%
FY 2008	71%	64%	60%	64%	64%
FY 2007	88%	84%	78%	78%	78%
FY 2006	89%	88%	89%	89%	89%
FY 2005	92%	91%	91%	90%	90%
FY 2004	88%	91%	91%	91%	91%
FY 2003	91%	90%	90%	90%	90%
FY 2002	89%	90%	89%	89%	89%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Recent changes in federal eligibility requirements, such as verification of citizenship, have greatly increased the complexity and processing time for each Medicaid application handled. During the first half of FY08 processing times far exceeded the 30-day standard. As a result, children have not received timely medical care, and payments to vendors and medical care providers have been delayed. The implementation of the federal Payment Error Rate Measurement (PERM) requirements further impacts processing timeframes by establishing higher expectations for program accountability and payment accuracy.

A5: Strategy - Improve accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.
Status #1: In FFY08, 92.6% of food stamp benefits were accurate.

Percentage of accurate food stamp benefits

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2009	93.8%	94.2%	95.1%	0	95.1%
FFY 2008	91.1%	93.9%	92.8%	92.6%	92.6%
FFY 2007	95.1%	96.3%	96.3%	96.1%	96.1%
FFY 2006	92.3%	93.5%	94.1%	94.3%	94.3%
FFY 2005	92.2%	93.2%	93.0%	93.8%	93.8%
FFY 2004	90.8%	94.2%	93.5%	93.3%	93.3%
FFY 2003	86.2%	84.7%	85.6%	86.4%	86.4%
FFY 2002	90.4%	92.4%	90.5%	89.2%	89.2%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

Target #2: 95% of temporary assistance benefits are accurate.
Status #2: The FFY07 Alaska Temporary Assistance benefit accuracy is 99%, a 5-year high.

Percentage of accurate temporary assistance benefits.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2009	98.8%	97.7%	0	0	97.7%
FFY 2007	99.4%	99.3%	99.1%	98.8%	98.8%
FFY 2006	98.1%	96.3%	97.7%	96.3%	96.3%
FFY 2005	98.5%	95.9%	95.7%	97.1%	97.1%
FFY 2004	96.7%	97.5%	98.2%	98.1%	98.1%
FFY 2003	94.4%	93.6%	94.5%	93.6%	93.6%
FFY 2002	88.2%	93.7%	93.6%	92.0%	92.0%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The Temporary Assistance accuracy reviews for FY08 were temporarily suspended due to the additional efforts needed to perform both the federally mandated Medicaid payment accuracy rate and Child Care accuracy measurements.

Target #3: 93% of Medicaid eligibility determinations are accurate.
Status #3: In FFY09, 99% of the Medicaid eligibility determinations were accurate.

Percentage of accurate Medicaid eligibility determinations

Fiscal Year	YTD Total
FFY 2009	99%
FFY 2007	96%
FFY 2006	95%
FFY 2005	93%
FFY 2004	99%
FFY 2003	99%
FFY 2002	96%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. Medicaid eligibility accuracy is compiled at the end of projects designed by the state and accepted by federal authorities.

A6: Strategy - Increase the percentage of subsidy children in licensed care.

Target #1: 76% of subsidy children are in licensed care.
Status #1: In FY09, 71% of children receiving child care assistance were in licensed care, down from 78% in FY06.

Percentage of subsidy children in licensed care

Fiscal Year	September	December	March	June	YTD Total
FY 2009	74%	74%	72%	71%	71%
FY 2008	73%	72%	73%	70%	73%
FY 2007	74%	74%	76%	74%	75%
FY 2006	80%	84%	75%	72%	78%
FY 2005	74%	81%	77%	80%	77%
FY 2004	75%	76%	76%	76%	76%
FY 2003	65%	66%	68%	75%	75%
FY 2002	0	60%	58%	64%	64%

Analysis of results and challenges: The first available data regarding this measure is the second quarter in 2002. There is a two month lag in the data.

The number of working families participating in the Child Care Assistance Program has decreased over the past year. The decrease is partially attributed to State rates for child care not keeping up with the rates that child care providers charge. As state rates decline in relation to the market rate, low income families on child care assistance are faced with an increased financial burden to pay the difference between the state rate and the child care provider's rate (in addition to their required co-payment) or to choose lower priced and usually lower-quality child care. The decline in state rates in relation to the market rate has resulted in fewer families being assisted by the Child Care Assistance Program and child care providers being less able to provide care at state payment levels. State rates for licensed child care providers who accept children on child care assistance were increased effective September 2008 as an initial step to bridge that gap.

Public Health Results Delivery Unit

Mission

Provide support services for the department's programs.

Core Services

- Prevent and control epidemics and the spread of infectious disease.
- Prevent and control injuries.
- Prevent and control chronic disease and disabilities.
- Respond to public health emergencies, disasters and terrorist attack.
- Assure access to early preventative services and quality health care.
- Protect against environmental hazards impacting human health.
- Manage and administer public health programs and services effectively and efficiently.
- Death investigation and medical examination to determine identity of deceased and cause of death.

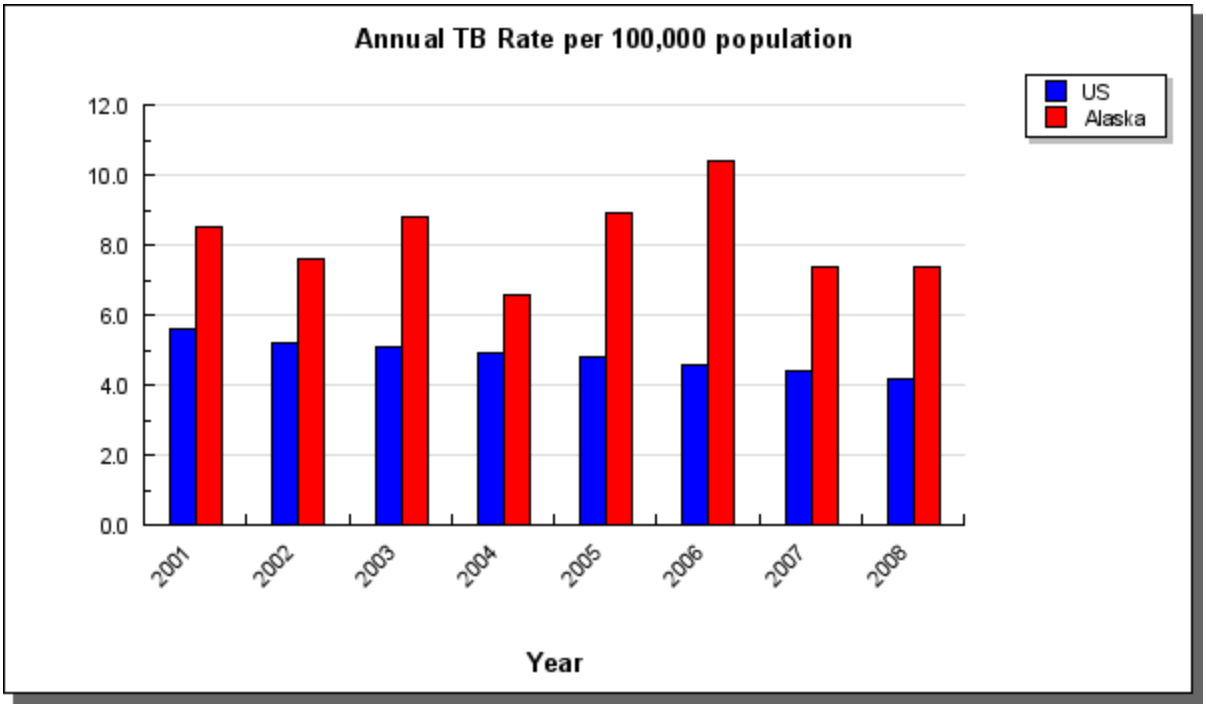
End Result	Strategies to Achieve End Result
A: Healthy people in healthy communities. Target #1: Alaska's tuberculosis (TB) rate is less than 6.8/100,000 population Status #1: The rate of TB was unchanged between 2007 and 2008. Target #2: Alaska's chlamydia rate is less than 590/100,000 population Status #2: Alaska's chlamydia rate decreased from 725 to 718 or less than 1% decrease in 2008, and increased from 675 to 725 or 7.41% in 2007 per 100,000 population. Alaska ranked second in the nation for chlamydia rates in 2007. Target #3: Alaska's coronary heart disease death rate is less than 120/100,000 population Status #3: Coronary Heart Disease (CHD) rate is below the target for each year since 2004 which is 120 deaths per 100,000 population. Target #4: Alaska's overall cancer death rate is less than 162/100,000 population Status #4: Cancer rate declined from 2000 through 2005, with a slight increase subsequently. Cancer is still the Number 1 killer in Alaska. Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population Status #5: The 2007 death rate caused by unintentional injuries was 57.3 per 100,000 population, above the 50/100,000 target and representing a nearly 10% increase from the 2006 rate. The rate dropped by 12% from 2002 to 2006.	**A1: Reduce the risk of epidemics and the spread of infectious disease.** Target #1: 95% of persons with tuberculosis (TB) will complete adequate treatment within one year of beginning treatment Status #1: In 2007, 90% of persons with tuberculosis (TB) completed adequate treatment; this was in line with prior year performance. This was below the target rate of 95% primarily due to some difficult cases. Target #2: At least 98% of chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines Status #2: 99.6% of Alaskans diagnosed with Chlamidia in calendar year 2008 received adequate treatment, exceeding the 98% target. **A2: Reduce suffering, death and disability due to chronic disease.** Target #1: Less than 17% of high school youth in Alaska smoke Status #1: There has been a 51% decline in youth smoking over 12 years, bringing the 2007 prevalence rate of 18% within 1 percentage point of the 17% target. **A3: Reduce suffering, death and disability due to injuries.** Target #1: Increase seatbelt use to 80% Status #1: Alaska has exceeded target since mandatory seatbelt law took effect in 2006. **A4: Assure access to early preventative services and**

	quality health care. Target #1: More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects. Status #1: In 2007, there was a significant decrease in the knowledge of folic acid benefits. Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually Status #2: In FY09, the state is on track to meet licensure survey timelines. **A5: Minimize loss of life and suffering from natural disasters and terrorist attack.** Target #1: 25% of the Division of Public Health (DPH) staff is trained in disaster response techniques and procedures Status #1: Target exceeded - in FY09 29% of all DPH staff received preparedness training. **A6: Reduce Alaskans' exposure to environmental human health hazards.** Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals Status #1: In FY08 100% certification has been maintained for heavy metals; PCB and Pesticides validation is on hold.

Performance Detail

A: Result - Healthy people in healthy communities.

Target #1: Alaska's tuberculosis (TB) rate is less than 6.8/100,000 population
Status #1: The rate of TB was unchanged between 2007 and 2008.



Annual TB Rate per 100,000 population

Year	US	Alaska
2008	4.2 -4.55%	7.4 0%
2007	4.4 -4.35%	7.4 -28.85%
2006	4.6 -4.17%	10.4 +16.85%
2005	4.8 -2.04%	8.9 +34.85%
2004	4.9 -3.92%	6.6 -25%
2003	5.1 -1.92%	8.8 +15.79%
2002	5.2 -7.14%	7.6 -10.59%
2001	5.6	8.5

Analysis of results and challenges: Tuberculosis (TB) has been a longstanding problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, utilizing 10% of the entire 1946 state budget and additional federal resources, led to one of the state's most visible public health successes - major reductions in TB. Tremendous inroads have been made to control TB in Alaska, although periodic outbreaks, usually in rural Alaska, have taxed both local and state resources. In 2000, Alaska had the highest rate of TB of any state in the country and additional funding was needed to effectively control two large outbreaks. In 2004, a multi-village outbreak involving Bethel and several surrounding Yukon-Kuskokwim villages again required additional public health resources and enhanced local response efforts. Unrelated to that outbreak, four Alaskans died with TB in 2004 because of delayed diagnosis and treatment. In 2005 and 2006 Alaska had the highest rate of TB of the 50 states. This was the

result of a large outbreak among the homeless in Anchorage. For 2007, Alaska has the third-highest TB rate in the country. On an ongoing basis, even when there are no outbreaks, significant resources are needed to do the TB case finding, diagnostic tests and treatment follow-up necessary to keep this disease in check. In addition, for every person with TB, there are, on average, 16 people who were exposed and must also be found, evaluated, and often treated as well.

Alaska's population is small, so a small number of cases can dramatically affect the statewide rate. Despite the recent outbreaks, the rate of TB in Alaska began to decline again in 2007 and has held steady in 2008. The state TB rate shows a downward trend over the past 12 months.

Because of a high rate of latent TB infection among residents, and Alaska's location as a global crossroads that attracts travelers, seasonal workers and new families, rates of TB are expected to fluctuate and remain higher than the national average over the next generation. TB remains deeply entrenched in many regions of Alaska, while the homeless and foreign-born residents also suffer disproportionate rates of the disease.

To control the ongoing challenge of TB, the department needs a strong and multi-pronged public health team of professionals knowledgeable about current issues of TB control as well as a strong public health nursing force. Such expertise will always be necessary if the disease once called the "Scourge of Alaska" is to be controlled and eventually eliminated.

Target #2: Alaska's chlamydia rate is less than 590/100,000 population
Status #2: Alaska's chlamydia rate decreased from 725 to 718 or less than 1% decrease in 2008, and increased from 675 to 725 or 7.41% in 2007 per 100,000 population. Alaska ranked second in the nation for chlamydia rates in 2007.

Chlamydia rate per 100,000 of population

Year	Alaska	U.S.
2008	718 -0.97%	N/A
2007	725 +7.41%	370 +6.32%
2006	675 +2.9%	348 +4.5%
2005	656 +7.72%	333 +4.06%
2004	609 +1.16%	320 +5.26%
2003	602 +1.52%	304 +5.19%
2002	593 +36.64%	289 +5.09%
2001	434 +6.11%	275 +9.56%
2000	409 +34.98%	251 +1.62%
1999	303	247

*Methodology: National data for CY 2008 will be available from CDC by January 2010. *2008 rates based on 2007 AK Department of Labor & Workforce Development Population Estimates. 2008 Population Estimates will be available in late 2009.*

Analysis of results and challenges: Sexually transmitted infections remain major causes of illness in Alaska and may cause serious health consequences. Some diseases once under control have, in recent years reemerged, such as syphilis. As well, evolving antimicrobial resistance is rendering certain antibiotics ineffective.

Many challenges remain. More sensitive diagnostic technologies, targeted screening, and increased disease investigation activities have detected more infections, increasing the total numbers of chlamydia cases diagnosed. Rapid identification, notification, testing, and treatment of sexual contacts of individuals with chlamydia can make it possible to treat exposed individuals before they develop symptoms or further transmit infection. Conducted with sufficient intensity and sustained overtime, these activities have been shown to reduce the reservoir of infected individuals in the population, reducing case numbers and rates over time. Expanded programmatic efforts stabilized

chlamydia rates in 2003-2004 but these efforts could not be sustained; rates have increased since that time.

The basic public health infrastructure for sexually transmitted disease (STD) and HIV prevention and control is in place: public health expertise for patient follow up and partner notification; high quality public health laboratory services; and capacity for epidemiologic support, data analysis, and data dissemination. Some elements of this infrastructure, especially trained personnel to conduct partner notification services, currently require additional resources to strengthen and expand them to a level sufficient to address needs. All elements require ongoing maintenance and monitoring. Most of the financial resources currently identified to support STD prevention and control are federal and have declined over the past six years. Buying power has been eroded by increased costs of living and increased Department of Health and Social Services indirect costs. New resources are needed to expand program efforts.

Target #3: Alaska's coronary heart disease death rate is less than 120/100,000 population
Status #3: Coronary Heart Disease (CHD) rate is below the target for each year since 2004 which is 120 deaths per 100,000 population.

Age-Adjusted Coronary Heart Disease death rate per 100,000

Year	Alaska	US
2007	84.2 -3.22%	125.2 -7.19%
2006	87.0 -4.29%	134.9 -6.58%
2005	90.9 -4.11%	144.4 -3.86%
2004	94.8 -25.18%	150.2 -7.74%
2003	126.7 +7.28%	162.8 -4.74%
2002	118.1 -13.61%	170.9 -3.88%
2001	136.7 -0.73%	177.8 -4.82%
2000	137.7 +4.71%	186.8 -4.01%
1999	131.5	194.6

Analysis of results and challenges: Nationally, heart disease is the leading cause of death. An estimated 12 million men and women in the U.S. have a history of coronary heart disease, the most common form of heart disease. In 2005, 652,091 people (50.5% of them women) died of coronary heart disease in the U.S.. Although death rates from coronary heart disease have declined since the late 1960s, the decline has slowed since 1990. The lifetime risk for developing this disease is very high in the United States. One of every two males and one of every three females aged 40 years and under will develop heart disease some time in their lives.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease (stroke) is the fourth. Over the past decade, Alaska's age-adjusted mortality rate for coronary heart disease has continued to decline. This mirrors the national trend, although Alaska's rates fall consistently below those found in the U.S. overall. Since 2004, Alaska's coronary heart disease death rates have been below the Healthy Alaskans 2010 target, which is 120 deaths per 100,000 population.

While there is no hard data to explain the downward trend in coronary heart disease deaths, it is likely that improvements in medical care are prolonging life, even for patients with advanced heart disease. In addition, Alaskans diagnosed with heart disease sometimes move south to receive treatment; their eventual deaths are not recorded in this state.

Target #4: Alaska's overall cancer death rate is less than 162/100,000 population
Status #4: Cancer rate declined from 2000 through 2005, with a slight increase subsequently. Cancer is still the Number 1 killer in Alaska.

Age-adjusted cancer death rate per 100,000 of population

Year	Alaska	US
2007	183.9 +3.43%	177.5 -1.77%
2006	177.8 +4.77%	180.7 -1.69%
2005	169.7 -7.87%	183.8 -1.08%
2004	184.2 -1.97%	185.8 -2.26%
2003	187.9 -0.9%	190.1 -1.76%
2002	189.6 -1.35%	193.5 -1.28%
2001	192.2 -8.3%	196.0 -1.8%
2000	209.6 +8.88%	199.6 -0.6%
1999	192.5	200.8

Analysis of results and challenges: Cancer has been the leading cause of death in Alaska since 1993, one of the few states in the United States for which this occurs. There are more than 100 different types of cancer that comprise this group of diseases characterized by the uncontrolled growth and spread of abnormal cells. These abnormal cells can invade surrounding tissues and spread to other parts of the body through the blood and lymph systems. If the spread is not controlled, it can result in death.

In the United States, cancer is the second-leading cause of death after heart disease, accounting for 1 of every 4 deaths. Over the past ten years there has been a declining trend in the cancer death rate in the United States. Alaska has generally mirrored that trend with the exception of the last two years, where an increase was noted. The Healthy Alaskans 2010 target is 162 deaths per 100,000 population.

The most common types of cancer deaths in Alaska for women are, in order, lung, breast and colorectal cancers. For men, the most common types of cancer deaths are lung, colorectal and prostate. Although some cancer risk factors are not modifiable such as heredity, age and sex, it is estimated that up to two-thirds of cancer deaths may be prevented by changing unhealthy behaviors. These behaviors include tobacco use, excessive alcohol intake, poor diet, lack of exercise, excessive sunlight exposure, and sexual behaviors that increase exposure to certain viruses.

The Alaska Comprehensive Cancer Control Program works collaboratively with communities and partners around the state to positively impact the cancer burden in Alaska. Goals are established that promote cancer prevention, improve early detection, increase access to health and social services, maximize the quality of life for cancer survivors, and reduce suffering and death from cancer. The Alaska Tobacco Prevention and Control Program works toward “a tobacco-free Alaska” through goals around prevention, cessation, education, advocacy and public policy.

Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population
Status #5: The 2007 death rate caused by unintentional injuries was 57.3 per 100,000 population, above the 50/100,000 target and representing a nearly 10% increase from the 2006 rate. The rate dropped by 12% from 2002 to 2006.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
2007	57.3 +9.98%	N/A
2006	52.1 +2.96%	N/A
2005	50.6 -8%	39.7 +4.2%
2004	55.0 -0.54%	38.1 +1.33%
2003	55.3 -6.59%	37.6 +1.62%
2002	59.2 -3.11%	37.0 +3.64%
2001	61.1 -4.38%	35.7 +2.59%
2000	63.9 +11.13%	34.8 -0.85%
1999	57.5	35.1

Methodology: U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

Analysis of results and challenges: Injuries are a significant public health and social services problem because of Alaska's high prevalence, the toll on the young and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries. Unintentional injuries are the third leading cause of death in Alaska. Cancer and heart disease are the leading causes of death among the elderly, but injuries are the leading cause of death in children and young adults.

The Division of Public Health along with its many partners continues to see the benefits of actions related to injury control and prevention. The Safe Boating Act and Kids Don't Float programs are two examples of successful activities. DPH's Injury Control program will continue to partner with others and to use data analysis and prevention strategies to understand and target interventions.

A1: Strategy - Reduce the risk of epidemics and the spread of infectious disease.

Target #1: 95% of persons with tuberculosis (TB) will complete adequate treatment within one year of beginning treatment

Status #1: In 2007, 90% of persons with tuberculosis (TB) completed adequate treatment; this was in line with prior year performance. This was below the target rate of 95% primarily due to some difficult cases.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2008	N/A*
2007	90%
2006	90%
2005	92%
2004	86%
2003	93%
2002	93%

*Methodology: *TB treatment requires 6-9 months for completion. Some 2008 cases are still being treated.*

Analysis of results and challenges: The highest priority for TB control is to ensure that persons with the disease are diagnosed early and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. However, some TB patients are difficult to locate, are noncompliant or have medical complications that don't allow them to receive full treatment within the allotted time period. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

Target #2: At least 98% of chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines
Status #2: 99.6% of Alaskans diagnosed with Chlamidia in calendar year 2008 received adequate treatment, exceeding the 98% target.

% of Chlamydia cases prescribed adequate treatment

Year	Annual
2008	99.6%
2007	99.8%
2006	97.9%
2005	99.8%
2004	99.6%
2003	99.5%

Analysis of results and challenges: Analysis of results and challenges: HIV/STD program staff follow up to assure adequate treatment is prescribed for all reported chlamydia cases. Given such follow up, the majority of cases are ultimately treated in a manner consistent with the national guidelines. Challenges include maintaining resources necessary to conduct necessary follow up and carefully monitoring disease trends to identify emerging problems.

There were a total of 4,860 reported chlamydia cases in 2008, compared to 4,911 in 2007. A small number of cases don't get adequate treatment, due primarily to individuals refusing treatment or an inability to locate them.

A2: Strategy - Reduce suffering, death and disability due to chronic disease.

Target #1: Less than 17% of high school youth in Alaska smoke
Status #1: There has been a 51% decline in youth smoking over 12 years, bringing the 2007 prevalence rate of 18% within 1 percentage point of the 17% target.

Prevalence of cigarette smoking in Alaska youth in past 30 days (per YRBS survey)

Year	Alaska	US
2007	17.8	20.0 -13.04%
2005	NA	23.0 +5.02%
2003	19.2	21.9 -23.16%
2001	NA	28.5 -18.1%
1999	NA	34.8

Methodology: Data is collected every other year. Alaska data not released in years when a statistically valid sample is not available. U.S. data will be reported when released by the CDC.

Analysis of results and challenges: Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking, being overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening. Smokers' risk of heart attack is more than twice that of nonsmokers. Chronic exposure to environmental tobacco smoke (second-hand smoke) also increases the risk of heart disease. Cigarette smoking is also an important risk factor for stroke.

Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

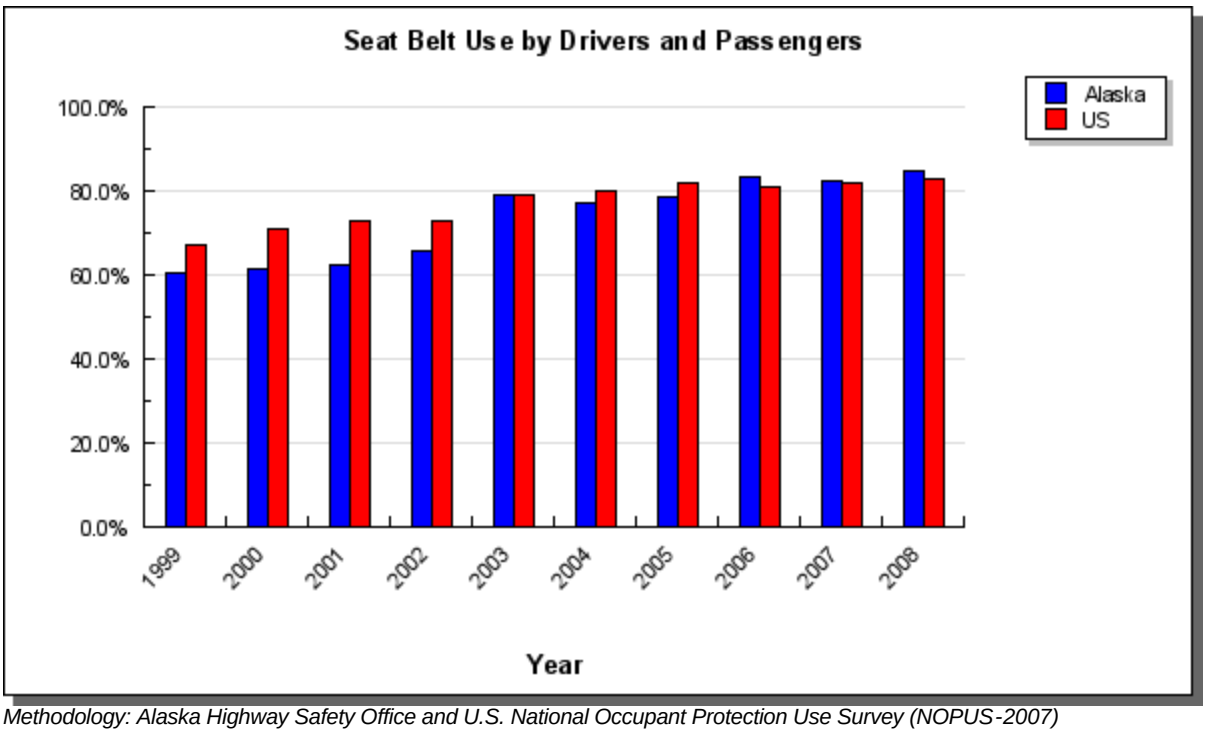
In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.2% in 2003 and 17.8% in 2007. Data are available from the Youth Risk Behavior Survey when enough Alaska schools participate to give results that can be generalized to the high school population as a whole in the state. This was the case only in 1995, 2003 and 2007. Surveys occurred in other years; however, schools did not have enough participants to provide

statewide results. It is the goal of the Division of Public Health to continue to work with schools to collect a representative sample every other year.

The Healthy Alaskans 2010 target is 17.0%.

A3: Strategy - Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80%
Status #1: Alaska has exceeded target since mandatory seatbelt law took effect in 2006.



Methodology: Alaska Highway Safety Office and U.S. National Occupant Protection Use Survey (NOPUS-2007)

Seat Belt Use by Drivers and Passengers

Year	Alaska	US
2008	84.9%	83%
2007	82.4%	82%
2006	83.2%	81%
2005	78.4%	82%
2004	77.0%	80%
2003	78.9%	79%
2002	65.8%	73%
2001	62.6%	73%
2000	61.3%	71%
1999	60.6%	67%

Analysis of results and challenges: Injuries are a significant public health and social services problem because of their prevalence, the toll of injuries on the young and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries and death. Unintentional injuries are the third leading cause of death in Alaska.

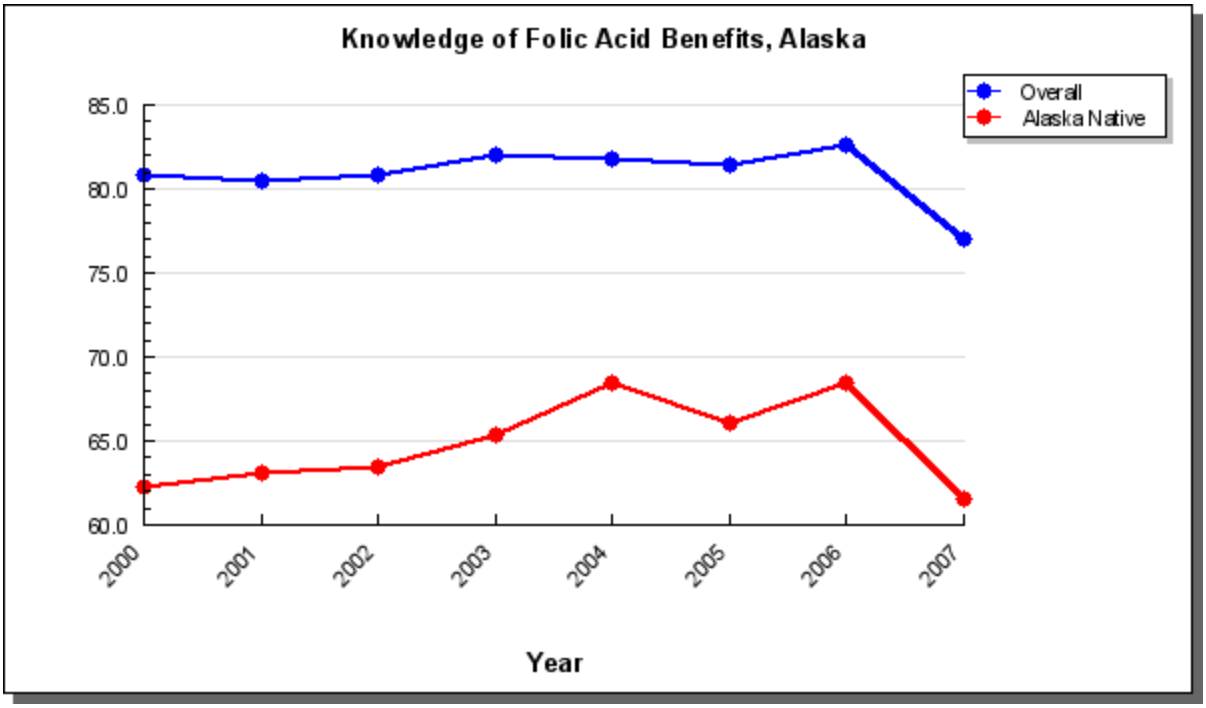
Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is most effective in reaching a higher level of seatbelt use compliance.

Alaska's manadatory seatbelt law took effect in 2006. In addition, efforts are ongoing to increase seatbelt use through public information messages and other targeted activities.

The Healthy Alaskans 2010 target is 80 percent seatbelt usage.

A4: Strategy - Assure access to early preventative services and quality health care.

Target #1: More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.
Status #1: In 2007, there was a significant decrease in the knowledge of folic acid benefits.



Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
2007	77.0 -6.78%	61.5 -10.09%
2006	82.6 +1.47%	68.4 +3.48%
2005	81.4 -0.49%	66.1 -3.36%
2004	81.8 -0.24%	68.4 +4.75%
2003	82.0 +1.49%	65.3 +2.83%
2002	80.8 +0.37%	63.5 +0.63%
2001	80.5 -0.37%	63.1 +1.28%
2000	80.8	62.3

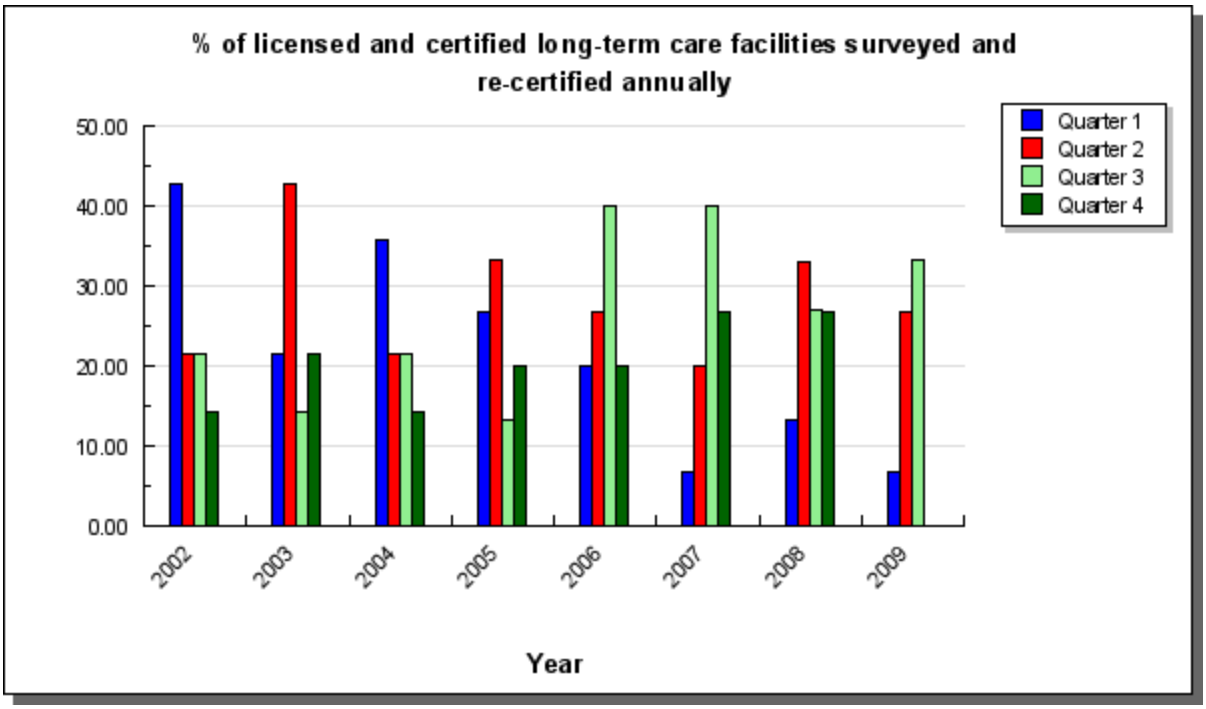
Analysis of results and challenges: From 2000 to 2006, the knowledge of folic acid benefits among Alaska mothers had remained at about the same level, around 81% to 83%. However, in 2007 there was a 7% decline in the proportion of mothers who had folic acid knowledge.

The proportion of Alaska Native mothers who know about the benefits of folic acid steadily increased to a high of

68.4% in 2004, fell slightly following year, and then rose again to 68.4%, only to fall below 2000 levels, to 61.5%. The gap in knowledge between Alaska Natives and Alaskan mothers still exists.

For women of childbearing age, increasing folic acid use by taking multivitamins before and during pregnancy can reduce the risk of neural tube birth defects. Numerous public education campaigns have sought to increase women's knowledge of the benefits of folic acid supplementation and educate them especially about the importance of the timing (pre-pregnancy supplementation is ideal). Efforts should focus on increasing the overall knowledge prevalence to 90% and minimizing racial disparities.

Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually
Status #2: In FY09, the state is on track to meet licensure survey timelines.



% of licensed and certified long-term care facilities surveyed and re-certified annually

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2009	6.67	26.67	33.33	0	66.67
2008	13.33	33	27	26.67	100%
2007	6.67	20	40	26.67	93.34%
2006	20	26.7	40	20	106.7%
2005	26.67	33.33	13.33	20	93.33%
2004	35.71	21.43	21.43	14.29	92.86%
2003	21.43	42.86	14.29	21.43	100%
2002	42.86	21.43	21.43	14.29	100%

Analysis of results and challenges: The annual required schedule for nursing home licensure surveys is driven by the federal Medicare certification survey scheduling mandate. The two surveys are always conducted simultaneously. The Center for Medicare and Medicaid Services (CMS) requires that long-term care (LTC) surveys are to be completed within a 9- to 15-month period with an average not to exceed 12.9 months. The Section of Certification and Licensing has consistently met federal and state certification and licensing LTC survey percentage requirements for licensed and certified long-term care facilities within the 9- to 15-month period. The Section's scheduling is affected by significant increases or decreases in complaints or reports of harm, and by significant changes in staff resources.

A5: Strategy - Minimize loss of life and suffering from natural disasters and terrorist attack.

Target #1: 25% of the Division of Public Health (DPH) staff is trained in disaster response techniques and procedures

Status #1: Target exceeded - in FY09 29% of all DPH staff received preparedness training.

 # and % of Division of Public Health staff trained in disaster preparedness

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2009	89	60	0	0	29%
FY 2008	177				34%
FY 2007	27	106	17	31	35%
FY 2006				144*	28%
FY 2005			70	103	27%

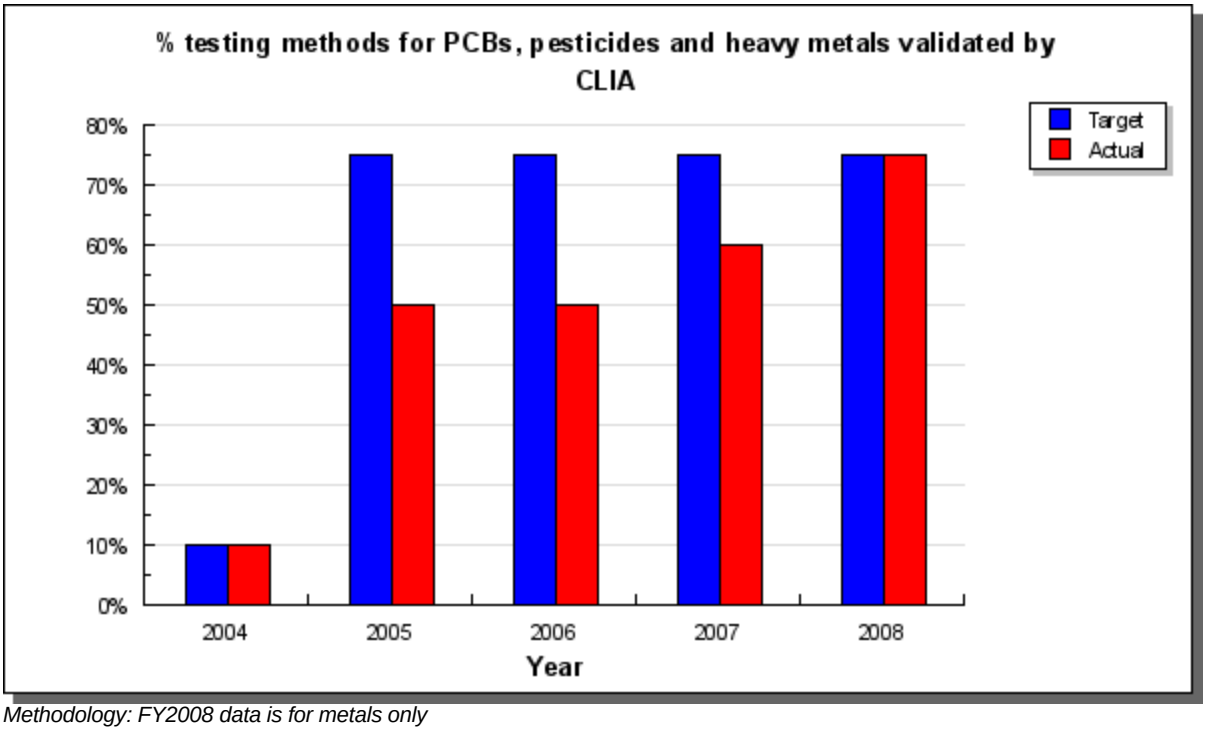
Analysis of results and challenges: Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action, and permits all concerned to maintain a common knowledge base.

The FY09 percentage reflects the following: 519 permanent full time DPH positions, with an estimated 149 individuals receiving disaster preparedness training, a total of 29 percent trained. This meets the division goal of 25 percent annually.

A6: Strategy - Reduce Alaskans' exposure to environmental human health hazards.

Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals

Status #1: In FY08 100% certification has been maintained for heavy metals; PCB and Pesticides validation is on hold.



Methodology: FY2008 data is for metals only

% testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2008	75%	75%
2007	75%	60%
2006	75%	50%
2005	75%	50%
2004	10%	10%

Analysis of results and challenges: PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus and young children. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. Direct analytical testing of human blood and hair for these compounds provides a real measure of human exposure to contaminants, rather than relying on hypothetical risk models. To date this type of testing has confirmed the safety of traditional foods. Mercury monitoring data has also provided a scientific basis supporting State recommendations regarding a healthy diet for rural and urban Alaskans.

During FY09, the hair mercury testing program will continue and we anticipate increasing throughput capacity for children's blood lead (Pb) testing. As a pilot, capillary blood lead testing was provided to a small subset of Head Start program children. Data from blood lead testing may be useful in identifying communities potentially at risk possibly due to poor practices in handling lead used during subsistence food gathering (i.e. fishing), or improved practices for cleaning lead shot game meats.

Currently there has been little community interest in PCB or pesticides testing conducted by the State. These tests are more expensive to complete, therefore further work on these compounds has been put on hold.

Senior and Disabilities Services Results Delivery Unit

Mission

Promote the independence of Alaskan seniors and persons with physical and developmental disabilities.

Core Services

- Provide support for institutional and community based services for older Alaskans and persons with disabilities.
- Provide protection of vulnerable adults.

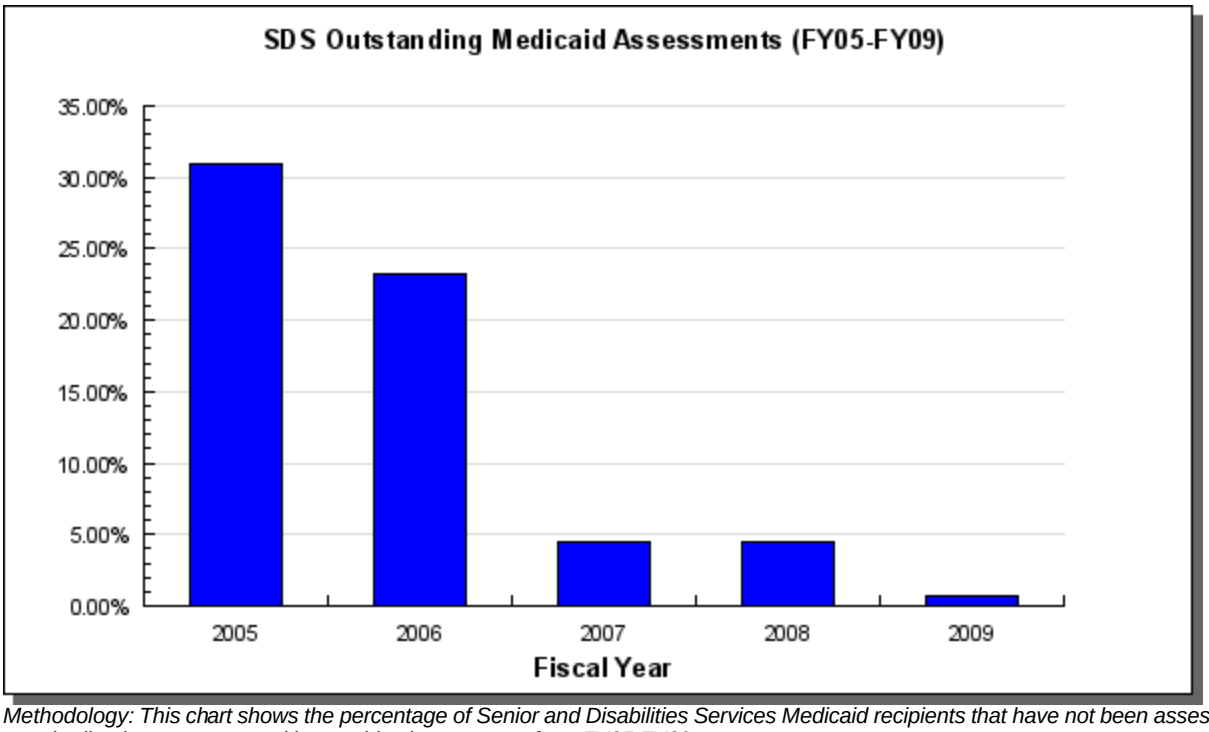
End Result	Strategies to Achieve End Result
A: The quality of life for seniors and persons with disabilities is enhanced through cost-effective delivery of services. Target #1: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%. Status #1: The percentage of Medicaid recipients not receiving medical assessments in FY09 was 1%, comparing favorably with the target of less than five percent.	**A1: Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.**
End Result	**Strategies to Achieve End Result**
B: Promote improved service and compliance with federal/state regulations through provider agencies. Target #1: Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies. Status #1: Current Medicaid payment error rates were less than 10% each year from FY05-FY07. However, as audits continue for 2006, the error rate has climbed sharply to slightly over 30%. Although apparently alarming, it is notable that the results of two specific audits, with error rates 100% and 76% respectively, have skewed the average higher. When those two audits are finally resolved, we anticipate that the error rate will be considerably lower. SDS will continue to strive towards more provider agency training. Current Myers and Stauffer results for FY08 remain unavailable, but will be included when available.	**B1: Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide eight care coordination training sessions each year in Alaskan communities.**
End Result	**Strategies to Achieve End Result**
C: A manageable caseload number in Adult Protective Services (APS) and Quality Assurance Units are ensured to provide timely investigations. Target #1: Reduce APS staff assigned case loads by 10%. Status #1: The National Adult Protective Services	

Association recommends an average case load of 25 cases per worker. The national average is approximately 35 cases per worker. SDS Adult Protective Services staff carry case loads of approximately 78 cases per case investigator, more than 3 times the recommended national average. Target #2: Reduce length of time a case is open by 10%. Status #2: Adult Protective Services case investigators have ten days to investigate a report of harm, abuse and/or neglect. The highest average number of days it takes to investigate a new case is 2.2 days.	

Performance Detail

A: Result - The quality of life for seniors and persons with disabilities is enhanced through cost-effective delivery of services.

Target #1: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%.
Status #1: The percentage of Medicaid recipients not receiving medical assessments in FY09 was 1%, comparing favorably with the target of less than five percent.



Methodology: This chart shows the percentage of Senior and Disabilities Services Medicaid recipients that have not been assessed using a standardized assessment tool by an objective assessor from FY05-FY09.

SDS Outstanding Medicaid Assessments (FY05-FY09)

Fiscal Year	% Not Reviewed
FY 2009	.77
FY 2008	4.5%
FY 2007	4.5%
FY 2006	23.18%
FY 2005	30.9%

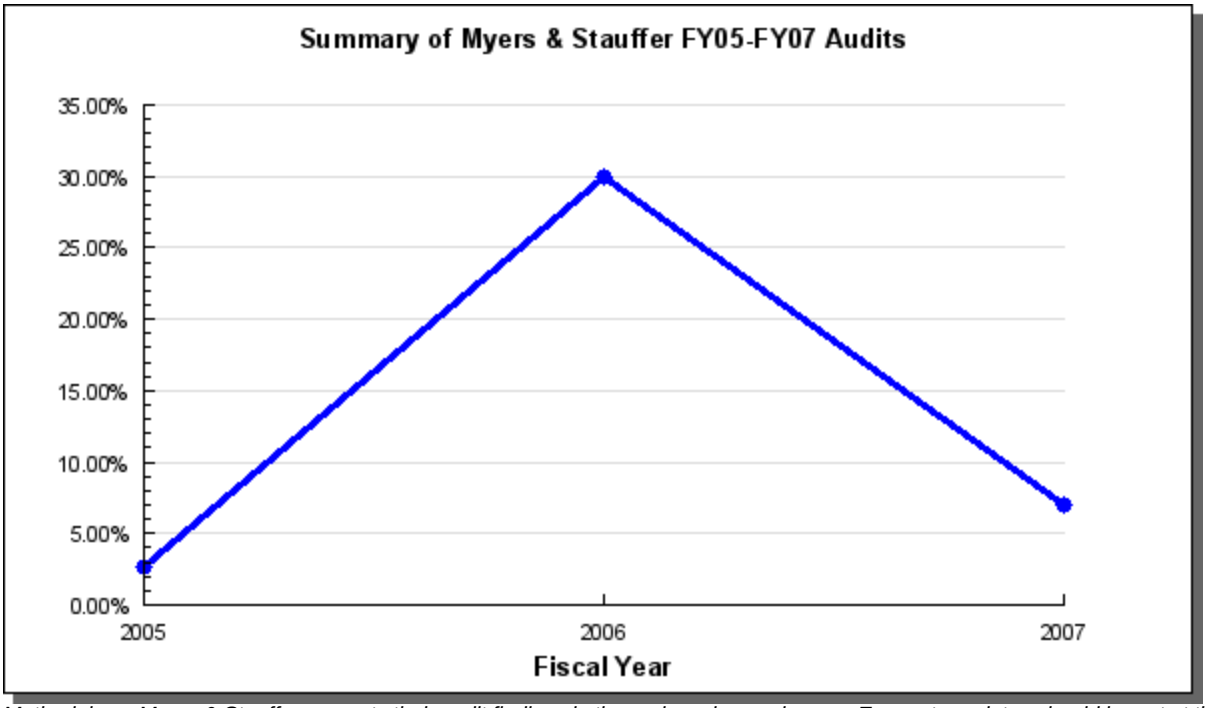
Analysis of results and challenges: The Personal Care Attendant (PCA) program was the only Medicaid program that did not require a state-approved medical assessment to receive services until implementation of new regulations in April of 2006. These new regulations began requiring a state-approved medical assessment and prior authorization of Medicaid benefits to ensure that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from FY2005-2008. Senior and Disabilities Services (SDS) has worked hard to catch up on back-logged Medicaid Waiver assessments through a contractor, state staff authorized to perform assessments and through agencies with staff on-site that have the appropriate credentials to complete assessments. In spite of these efforts, there were too many pending assessments required when new regulations went into effect in April of 2006 for the Personal Care Attendant program. SDS has dramatically decreased the assessment back-log but will not be caught up until all recipients receiving PCA services have been assessed. SDS is working hard to get all assessments completed within 30 days of assignment to an assessor.

A1: Strategy - Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.

B: Result - Promote improved service and compliance with federal/state regulations through provider agencies.

Target #1: Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies.

Status #1: Current Medicaid payment error rates were less than 10% each year from FY05-FY07. However, as audits continue for 2006, the error rate has climbed sharply to slightly over 30%. Although apparently alarming, it is notable that the results of two specific audits, with error rates 100% and 76% respectively, have skewed the average higher. When those two audits are finally resolved, we anticipate that the error rate will be considerably lower. SDS will continue to strive towards more provider agency training. Current Myers and Stauffer results for FY08 remain unavailable, but will be included when available.



Methodology: Myers & Stauffer presents their audit findings in the early spring each year. Error rate updates should be out at that time.

Summary of Myers & Stauffer FY05-FY07 Audits

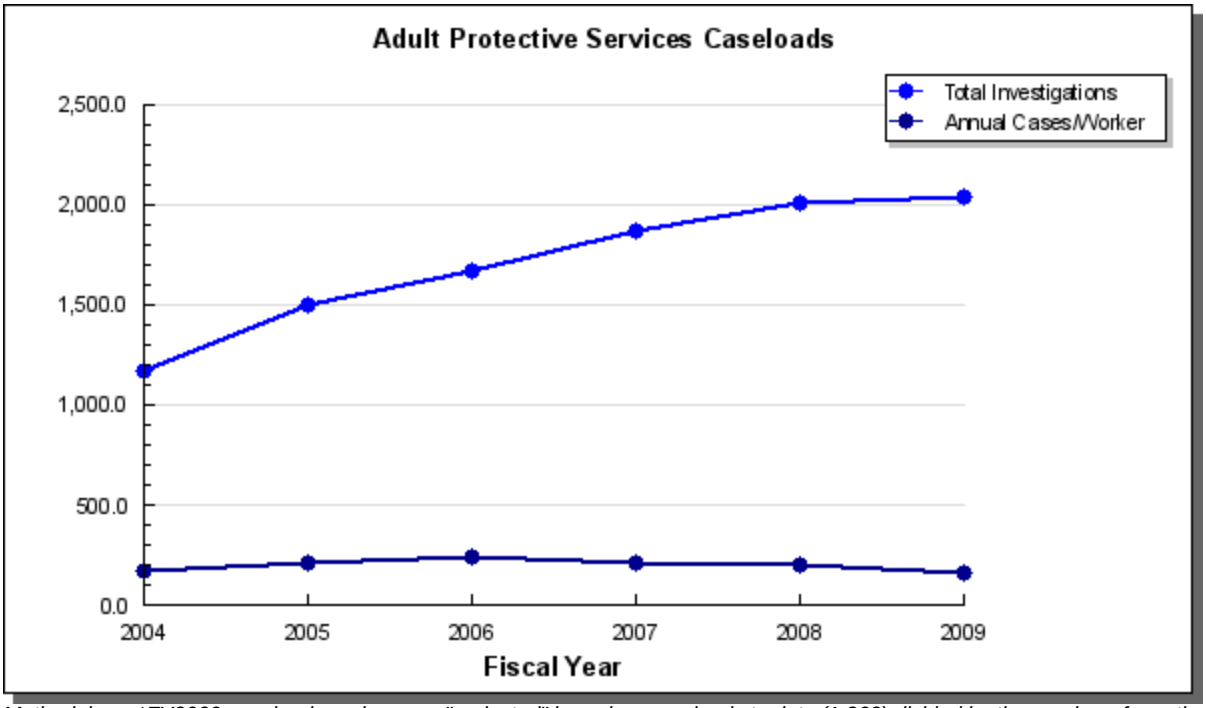
Fiscal Year	Error Rate
FY 2007	7.03%
FY 2006	30.01%
FY 2005	2.63%

Analysis of results and challenges: The chart shows SDS Medicaid programs that have been audited by Myers and Stauffer and the percentage of audit exceptions that have been assigned to each program after audit findings have been presented to the appropriate agencies and have been given a chance to respond. This process eliminates some intial audit findings. Audits are completed in the spring following the end of each fiscal year.

B1: Strategy - Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide eight care coordination training sessions each year in Alaskan communities.

C: Result - A manageable caseload number in Adult Protective Services (APS) and Quality Assurance Units are ensured to provide timely investigations.

Target #1: Reduce APS staff assigned case loads by 10%.
Status #1: The National Adult Protective Services Association recommends an average case load of 25 cases per worker. The national average is approximately 35 cases per worker. SDS Adult Protective Services staff carry case loads of approximately 78 cases per case investigator, more than 3 times the recommended national average.



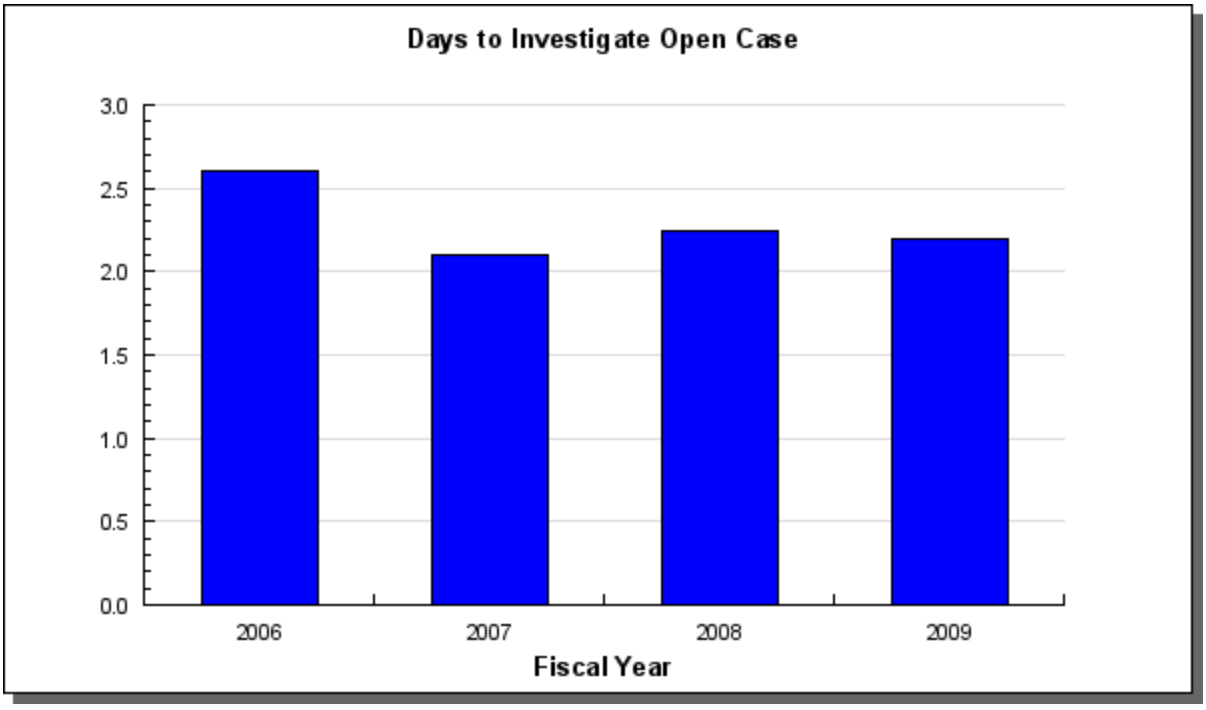
*Methodology: *FY2009 caseload numbers are "projected" based on caseloads to date (1,362) divided by the number of months that have elapsed in FY2009 (8). This number (170) is multiplied by remaining months (4) to project a total number of estimated cases for FY2009.*

Adult Protective Services Caseloads

Fiscal Year	Total Investigations	Full Time Workers	Annual Cases/Worker	Days to Investigate
FY 2009	2043 +1.49%	13 +30%	157.0 -19.9%	2.2 -1.79%
FY 2008	2013 +7.88%	10 +11.11%	196 -5.31%	2.24 +6.67%
FY 2007	1866 +12%	9 +28.57%	207 -13.03%	2.1 -19.23%
FY 2006	1666 +11.29%	7 0%	238 +11.21%	2.6 0%
FY 2005	1497 +27.62%	7 0%	214 +27.38%	0 0%
FY 2004	1173	7	168	0

Analysis of results and challenges: The annual caseload for an Adult Protective Services (APS) case worker was steadily on the rise from FY04 to FY06. From FY04 to FY05, the average caseload increased by more than 27%. From FY05 to FY06, the average caseload increased again, this time by more than 11%. From FY06 to FY07 the average caseload decreased by more than 13% after two new case workers were hired. Based on this unexpected growth, Senior and Disabilities Services has added five new positions since FY06. Because of these new positions, FY07 finally saw a decrease in the number of open cases per case worker. With the addition of two new positions in FY09, Senior and Disabilities Services will expect to see a decrease to the number of annual cases per case worker. The APS Unit received two new case manager positions in the FY09 budget and has just recently filled the last vacant position in the unit. With the new positions, the APS Unit will have four supervisors, seven case investigators, two case managers and two intake workers. With this many staff, SDS is optimistic that case load numbers will decrease to more manageable levels.

Target #2: Reduce length of time a case is open by 10%.
Status #2: Adult Protective Services case investigators have ten days to investigate a report of harm, abuse and/or neglect. The highest average number of days it takes to investigate a new case is 2.2 days.



Days to Investigate Open Case

Fiscal Year	Days to Investigated	YTD Total
FY 2009	2.2 -1.79%	2.2 -1.79%
FY 2008	2.24 +6.67%	2.24 +6.67%
FY 2007	2.1 -19.23%	2.1 -19.23%
FY 2006	2.6	2.6

Analysis of results and challenges: The average length of time it took to investigate a new case was approximately 2.6 days in FY06, when there were only seven case workers. In FY07, two additional case worker positions were added, bringing the average length of time to investigate a report of harm down to 2.1 days. In FY08, SDS added three additional positions, for a total of 12. With these new positions, Senior and Disabilities Services anticipates a decrease to the number of annual cases per worker of more than 13.75%. Senior and Disabilities Services anticipates that with additional new staff being added in FY09 that the number of days it takes to investigate a new case could drop to less than two days.